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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 163, No. 1, January 1983

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*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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The Impaired Physician

In recent months, the attention of the public, the profession and the legislature has focused on the problems attached to disciplining physicians who are incompetent, dishonest or guilty of a felony. This has resulted in an amendment to the Medical Practice Act which should make it easier to bar these physicians from medical practice.

A more covert but equally important problem pertains to the impaired physician. A physician may be impaired by poor physical or mental health, emotional problems, advanced age, alcohol or drug abuse or simply insufficient education in modern medical knowledge.

Whatever the reason, all physicians have a responsibility for our impaired colleagues. It is our duty whenever possible to see that they are rehabilitated to a productive medical life as soon and as compassionately as possible. Not only have the individual physician and the physician's family expended large financial and emotional resources in obtaining the education and training required to become a physician, but considerable public expenditures have been incurred as well. An early return to useful medical practice is to the advantage of both the physician and society in general.

To support this rehabilitative effort, the Illinois State Medical Society has established the Committee for the Impaired Physician, composed of physicians with expertise in this field. The committee encourages the development of similar committees by county medical societies or by hospital medical staffs and offers its services on a confidential basis to help individual physicians. Persons interested in getting help or further information may contact Dr. Lee Gladstone, the chairman of the committee, through the Society offices: (312) 782-1654. ◀

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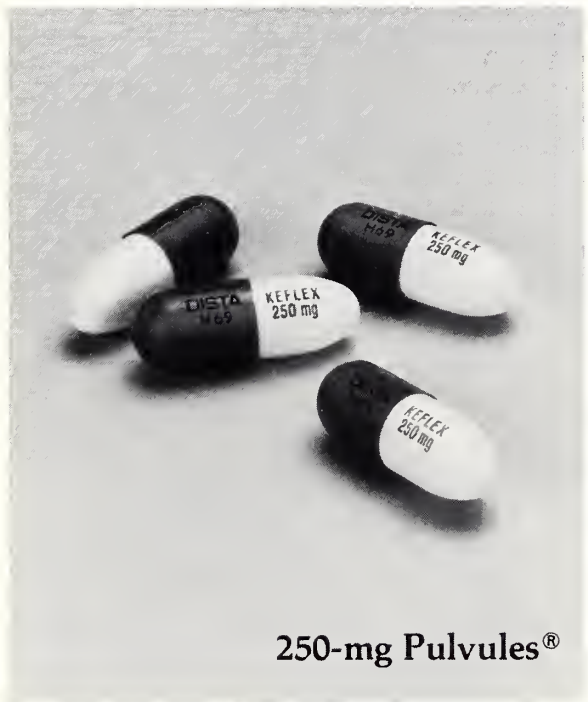
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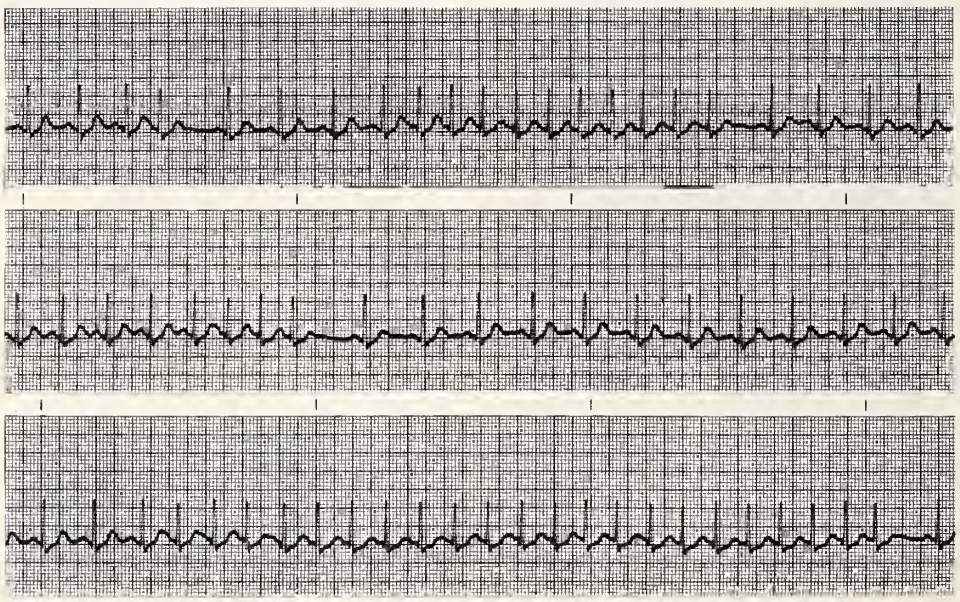
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EKG of the Month

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This patient is a fifty-four year old woman who had a twenty year history of episodic palpitations. These episodes were associated with lightheadedness and general fatigue. Recently, the palpitations had become much more frequent and were lasting up to one hour. During a prolonged bout of palpitations, she came to the emergency service. Her cardiac examination was significant for a mid systolic click and a late systolic murmur. A chest X-ray was normal. Intravenous verapamil was not used because she was hypotensive with a systolic blood pressure of 80mmHg. Intravenous digoxin broke the tachycardia and was continued in oral form. When short bursts of the palpitations recurred, quinidine was added. An exercise electrocardiogram was ordered to see if stress could induce the palpitations. In early recovery from exercise, the ECG strip was recorded.

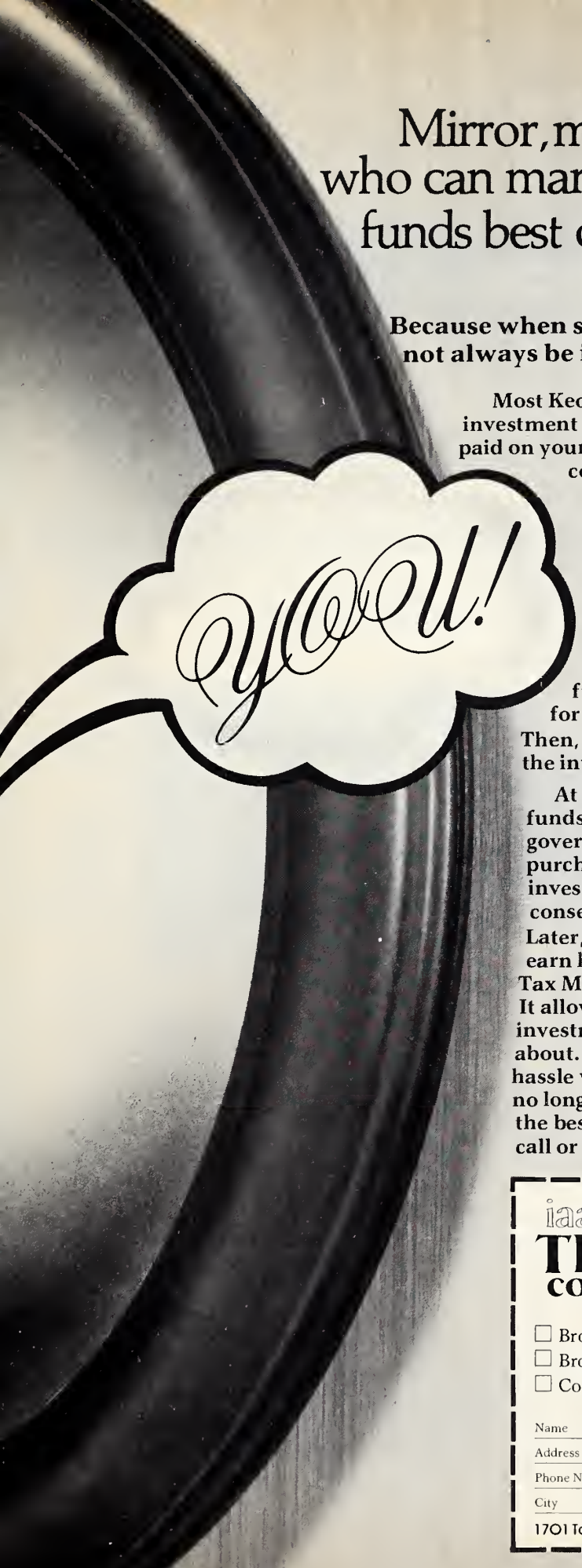


Questions:

1. **The ECG strip shows:**
   a. Paroxysmal atrial flutter.
   b. Paroxysmal atrial fibrillation.
   c. Paroxysmal supraventricular tachycardia.
   d. Sinus rhythm.
   e. Multifocal atrial tachycardia.

2. **Accepted treatments for this tachycardia include:**
   a. Digoxin, propranolol, verapamil.
   b. Carotid sinus massage.
   c. Quinidine, lidocaine.
   d. Direct current cardioversion.
   e. All of the above.

(Continued on page 16)



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The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's article was contributed by Kevin Corrigan, Ph.D., Department of Radiology, Loyola University Medical Center, Maywood, Illinois.

A 28 year old woman came to the emergency room because of sudden onset severe abdominal pain. She had a history of peptic ulcer disease and had had both an upper and lower GI examination and two chest radiographs when hospitalized 6 months before. She suspects she is pregnant and is extremely concerned about the potential effects of X-rays on a child, realizing the embryo is quite radiosensitive. She is also concerned about the danger of more radiation to herself because of her recent studies. She objects to having more radiographic examinations.



Figure 1

What would you do?

1. Delay radiography if necessary in order to observe the "ten day rule" which calls for limiting abdominal radiographs of a potentially pregnant woman to the first ten days after menstruation, since she is not likely to be pregnant during that time.
2. Do not order radiographs, since they are not advisable for a period of one year because of the woman's previously accumulated radiation burden and the heightened cancer risk from it.
3. Having discussed radiation and its risks with the patient, recommend a minimum number of abdominal radiographs since the potential benefits outweigh risks. Advise radiology personnel of the suspected pregnancy and request that films be limited to those absolutely required for diagnosis.
4. The referring physician need not concern himself with patient radiation risk when ordering radiologic studies.

(Continued on page 64)

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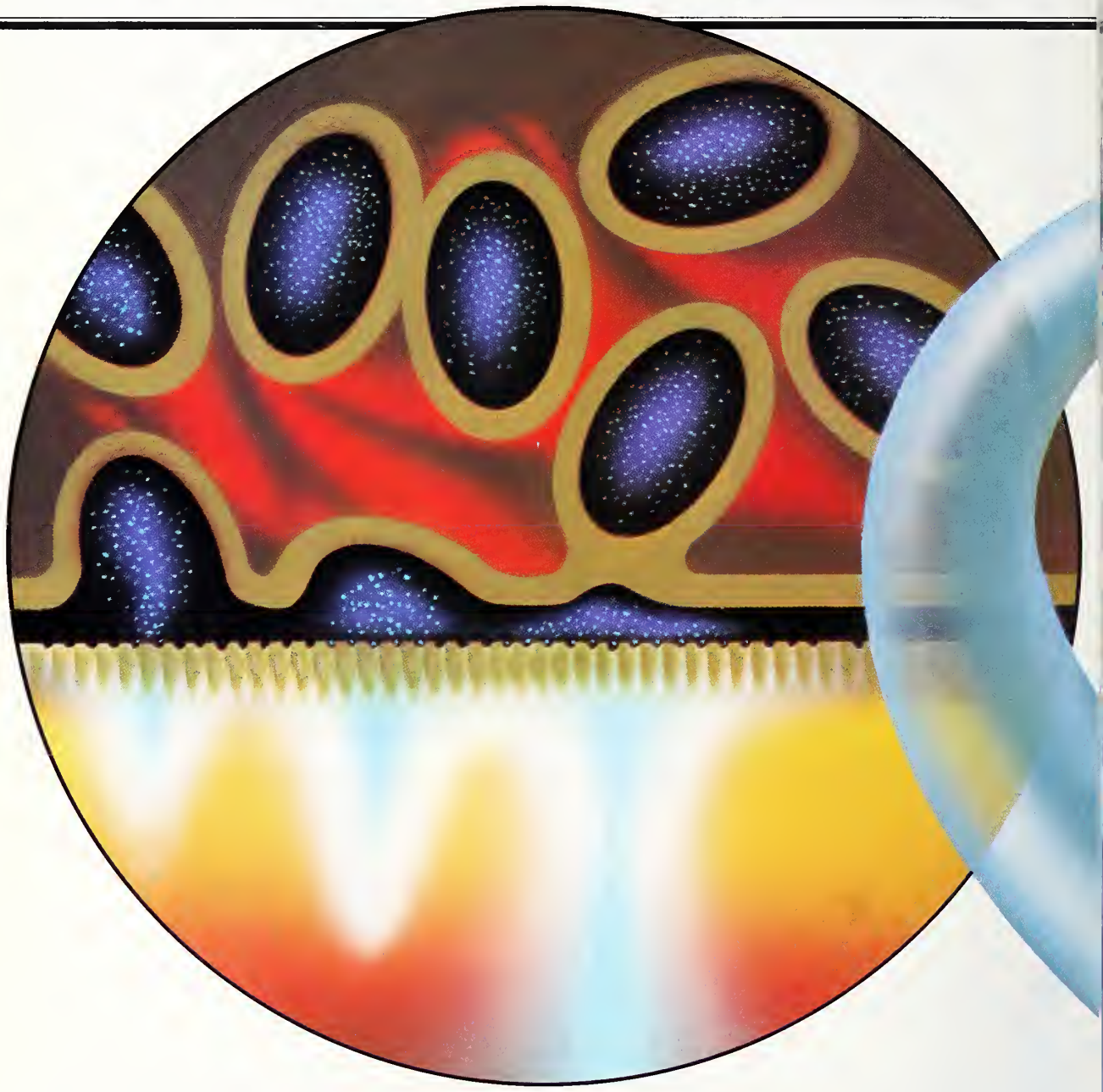
1. Pay 1983 ISMS dues
2. Join IMPAC today!

The 1982 elections are behind us. But IMPAC must begin now to build its resources for maximum effectiveness in the *1984* elections.

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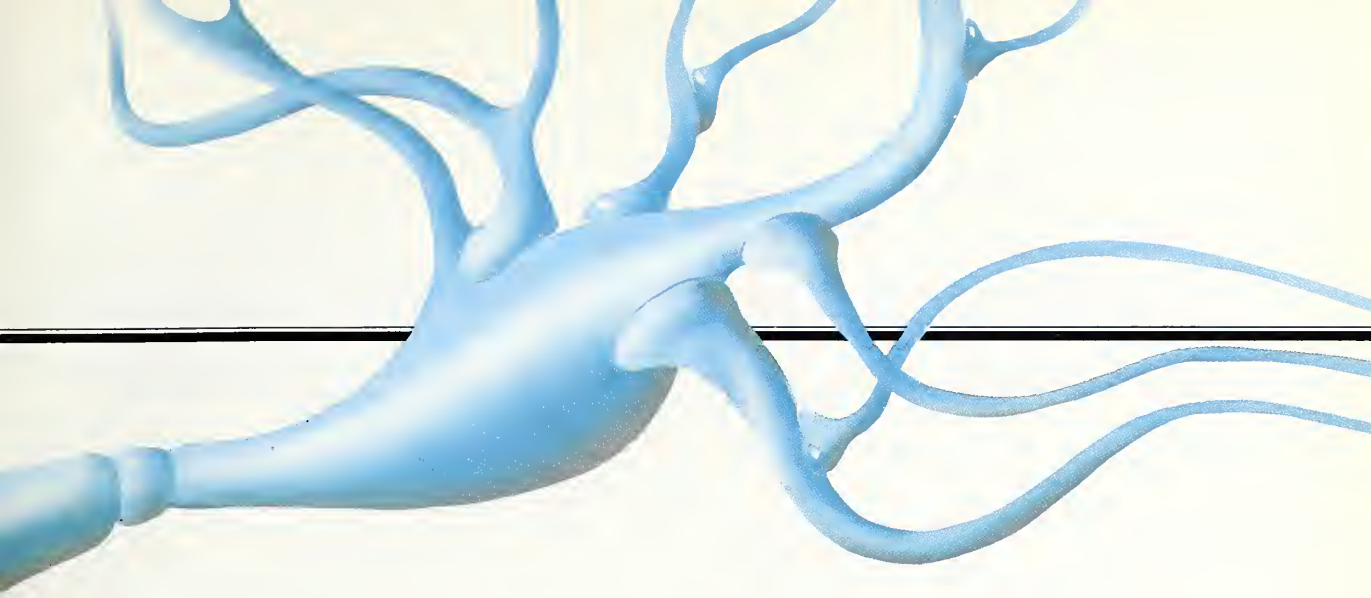
Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

VALIUM® (diazepam/Roche) IN THE FOREFRONT OF NEURORECEPTOR RESEARCH



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Opening new investigative pathways into where and how Valium (diazepam/Roche) exerts its distinctive antianxiety action

New discoveries in receptor research have stimulated the search for endogenous brain substances that may be involved in the mediation of anxiety.[1-5] It has been further theorized that these substances may act as ligands that bind to the same or similar sites as do benzodiazepine molecules[5,6]—binding sites early identified with the use of ^{3}H-diazepam.[5,7] These binding sites are now postulated to be benzodiazepine receptors, since the ability of benzodiazepines to bind with the sites appears to correlate with their clinical effects.[2,4,7,8]

Present investigations into clinical relevance of binding sites. Laboratories at Roche have conducted research to identify and isolate substances that may prove to be endogenous ligands, but no definitive identification has yet been made. Researchers are also studying substances which do not bind, but rather interact with the benzodiazepine binding sites—most notably gamma-aminobutyric acid (GABA)—and are postulated to mediate certain pharmacologic and clinical benzodiazepine effects.[2-4,9,10]

Under especially intense investigations are the GABA receptors and the benzodiazepine binding sites themselves—apparently constellations of closely linked but not identical structures.[8]

Future implications for improved therapy. In future work, Roche researchers and other scientists hope to identify and characterize various differential sites in the brain, which may result in more specific diagnostic and therapeutic approaches.

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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

References: **1.** Tallman JF *et al*: *Science 207*:274-281, Jan 18, 1980. **2.** Bunney WE Jr: *Psychiatr Ann 11*:11-15, Jan 1981. **3.** Davis JM *et al*: *J Clin Psychiatry 42*(11) Sec 2:4-14, Nov 1981. **4.** Study RE, Barker JL: *JAMA 247*: 2147-2151, Apr 16, 1982. **5.** Braestrup C, Nielsen M, Olsen CE: *Proc Natl Acad Sci USA 77*:2288-2292, Apr 1980. **6.** Basmann HB, Case KR, DiStefano P: *FEBS Lett 82*:368-372, Oct 1977. **7.** Braestrup C, Albrechtsen R, Squires RF: *Nature 269*:702-704, Oct 20, 1977. **8.** Snyder SH: *Psychosomatics 22*:986-989, Nov 1981. **9.** Rickels K: *J Clin Psychiatry 42*(11) Sec 2:40-44, Nov 1981. **10.** Haefely WE: *Br J Psychiatry 133*:231-238, Sep 1978.

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EKG

(Continued from page 10)

Answers:

1. C. D. 2. E

This ECG rhythm strip shows paroxysmal supraventricular tachycardia at a rate of 170 beats per minute. The fourth beat in the top strip is a premature atrial beat. Beats 9-18 in the top strip, beats 6-8 in the middle strip, and beats 4-25 in the bottom strip are beats of the paroxysmal supraventricular tachycardia. No clear P waves are discernible. The tachycardia starts with a premature atrial beat and ends abruptly. The QRS is normal in duration. Otherwise, the patient shows sinus rhythm at rates around 100 beats per minute. Atrial flutter and atrial fibrillation would show faster atrial activity. All of the methods of treatment in question two have been used successfully. In our patient, digoxin did not prevent the tachycardia if used alone. She developed diarrhea with quinidine.

Both propranolol and verapamil were successful when used orally but both made the patient symptomatically hypotensive. Cardioversion is not useful if the arrhythmia is episodic. Finally, disopyramide 150mg three times daily stopped the tachycardias. Approximately two-thirds of patients with paroxysmal supraventricular tachycardias have AV nodal reentry as the mechanism. Any drug which slows conduction in the AV node should prevent the tachycardia. This patient had normal ventricular function and mitral valve prolapse evaluated clinically. Still, she could not tolerate some of the medications. For the past three years, she has tolerated disopyramide and has had no symptomatic tachycardia. ◀

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: FAMILY PRACTITIONER. Excellent practice opportunity. Join young group of board-certified internists, family practitioner providing comprehensive health care for two counties in beautiful, wooded southern Illinois. Office adjacent to community hospital. Major state university (20 miles away), with medical school offers opportunity for affiliation. Administrative support provided. Guaranteed salary, bonus, fringes. Contact Susan Casey, Rural Health, Inc., 517 North Main Street, Anna 62906 (618-833-4471). (1)

AURORA: Dreyer Medical Clinic, S.C. Openings for Internal Medicine, Rheumatology, OB-Gyn & Urology in well established clinic of 42 physicians with associated satellite in rapidly growing area. Contact: L.E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506, 312-859-6700. (1)

CHRISTOPHER: Family Practitioner, Pediatrician, Obstetrician, Internist. Multi-Clinic Corporation in different locations throughout southern Illinois. Large resort area. Four weeks paid vacation, two weeks paid educational leave. Send curriculum vitae to: Jerry Cummings, Executive Director, PO Box 155, Christopher, Illinois 62822. (2)

DANVILLE: Family Physicians desiring independent practice near a larger community with two hospitals and wanting the security of start-up support with guarantees. Call N. L. Saxton, M.D. (217) 443-5204 or send curriculum vitae to 812 North Logan Avenue, Danville, 61832. (4)

GENEVA: SMALL TOWN MEDICINE/BIG CITY ADVANTAGES—Seeking physician to join board certified active family practice group. Thriving community of 10,000, west of Chicago. Modern, well equipped, 3 physician office with full lab and x-ray facilities. 110 bed primary care hospital 1 mile from office. Salary guarantee, malpratice coverage, other benefits. Opportunity for full partnership. Send resume and C.V. to: P.O. Box 72, Geneva, Illinois 60134. (3)

GRIGGSVILLE: North Pike County in immediate need of family practitioner. Practice partnership opportunity with established FP. Remodeled clinic, six months' free rent with supplies and basic equipment. 78-bed hospital with OB and C/CCU, pathologist and radiologist on site. Service area of 19,000 with 3 surgeons and 7 GPs (5 FAAFP). Medical student preceptorships on site and within one hour of family practice residency. One hour from Quincy, 1½ hours from Springfield, 2 hours from St. Louis. Excellent recreational facilities nearby. Contact Ronald Johnson, MD, FAAFP, 121 N. Franklin, Pittsfield 62363 (217-734-2386) or Cheryl Bielema, 110 N. Union, Griggsville 62340 (217-833-2665). (3)

LA HARPE:—Population 1200. Seeking replacement for one of two Family Physicians in community. 64 bed hospital including 49 long term; affiliation with nearby regional medical center; office facilities and financial assistance available. Educational/recreational facilities—Mississippi River nearby. Contact: Richard Miller, Administrator, La Harpe Hospital, La Harpe 61450, 217/659-3011. (3)

MUNSTER, IND. FAMILY PRACTICE-GP's: immediate need for primary care in large suburban multispecialty clinic. No OB. Excellent on site diagnostic available-including CT scan. 1st yr guarantee plus incentive. Partnership after 1 yr. No investment required. Contact: T. R. Hofferth, Director; Hammond Clinic, 7905 Calumet Ave., Munster, IN., 46321 (219) 836-5800 Collect. (1)

PINCKNEYVILLE: County Seat. 30 minutes to SIU-Carbondale. 75 minutes to St. Louis. Recent expansion of facilities provides space for a family practice physician to join three family practice physicians and a general surgeon. Lab, X-ray, and emergency room. Pharmacy on premises. Hospital one block away. Financial assistance available. Partnership status after one year. CONTACT: C. E. Cawvey, M.D., 206 North Main, Pinckneyville, 62274, 618-357-2131. (1).

ROSICLARE: FAMILY PRACTITIONER/INTERNAL MEDICINE—53-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare 62982. (618) 285-6634. (3)

STERLING-ROCK FALLS: Total population near 30,000. Two hours from Chicago, 1½ from Rockford and Peoria, one from Quad Cities. Outstanding recreational facilties. Modern 150-bed JCAH hospital; youngish medical staff, most specialties. No nurse shortage. Private or group practices. CONTACT: Darryl Wahler, CEO, Community General Hospital, 1601 First Avenue, Sterling, 61081, 815-625-0400. (1)

STREATOR: Otolaryngologist and neurologist needed as support to staff of 249-bed facility in North Central Illinois—Service area of 50,000—Excellent potential—Attractive office facilities close to hospital available—Financial assistance obtainable. Contact Terence Schuessler, Administrator, St. Mary's Hosptial, Streator (815-673-2311). (1)

Abstracts of Action

November 12-14, 1982 — *Sheraton-St. Louis, St. Louis, Missouri*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

AMICUS BRIEF

ISMS was notified by the Illinois State Medical Insurance Services that a recent lawsuit, involving several insureds, was a matter of extreme importance. The Exchange policy holders involved were named along with many other defendants in a recent lawsuit alleging medical negligence. The judge had refused to hear the case in Chicago as it involved an issue in another county, a different venue. The plaintiff took this on appeal directly to the Illinois Supreme Court as it is a case of first impression for intrastate application of the doctrine of *forum non-conveniens.* Since this has implications for many members, the Executive Committee recommended that ISMS enter the case as an *amicus curiae.* The Board ratified action authorizing counsel to file leave with the Supreme Court, to seek to assist the Court in description of a legal doctrine assuring that negligence suits are filed in the proper court as this relates to questions of venue.

IDPA PROGRAM ALTERNATIVES

The Board reviewed an extensive report from its Committee on Third Party Payment Processes regarding possible approaches to the structure of Medicaid. Various alternatives were described, as well as funding and reimbursement mechanisms. Some experimentation and pilot programs were suggested. In addition, a potential source of funding for a pilot project was identified. The Board agreed that the idea warranted further development and specific approaches in a demonstration project. This would allow opportunity for testing ideas in a small area.

Based upon this, the Board authorized the Third Party Payment Processes Committee, in conjunction with a committee of members appointed by the Chicago Medical Society, to develop a proposal for a joint ISMS-IDPA grant application for a pilot demonstration project based on the principles contained in the paper entitled, "Two Possible Models for ISMS-DPA Demonstration Project" (copy on file), and to bring such proposal back to the Board for consideration. In addition, the Board directed that ISMS and the Third Party Payment Processes Committee prepare a summary of IDPA RFPs on full service capitation plans and the action taken by the Society on the matter, for circulation to the membership.

ISMIS

The Board reviewed a report from the Chairman, ISMIS Board of Directors, indicating the current status of operations and the development of services. It was indicated that the Board is recommending further redemption of GFCs.

NEW FLEX EXAMINATION

Considerable controversy has emerged about a proposal by the Federation of State Medical Boards to develop a new two-part FLEX testing program to replace the current FLEX and the

(Continued on page 46)

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Elixir: Each 5 ml contains 12 mg codeine phosphate* plus 120 mg acetaminophen (alcohol 7%).
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Actions: Acetaminophen is an analgesic and antipyretic; codeine an analgesic and antitussive.
Contraindications: Hypersensitivity to acetaminophen or codeine.
Warnings: *Drug dependence:* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act.
Usage in ambulatory patients: Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.
Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.
Usage in pregnancy: Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.
Pediatric use: Safe dosage of this combination has not been established in children below the age of three.
Precautions: *Head injury and increased intracranial pressure:* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.
Special risk patients. Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.
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Illinois Society, American Association of Medical Assistants

Insurance Benefits Available To Illinois Society Members

Illinois Society, American Association of Medical Assistants, offers its members an extensive insurance plan. This has proven to be beneficial to the medical assistant in a small office which does not offer employer funded major medical benefits. There is no physical examination required for enrollment in most plans. Among the officially sponsored group insurance plans for members are:

Basic Major Medical—this low deductible plan pays 80% of eligible expenses up to $25,000. Coverage for dependents is also available.

Excess Major Medical—this plan picks up where the Major Medical Plan stops and provides optional dependent coverage. It is specifically designed to cover hospital, medical and surgical expenses in excess of those covered by most major medical plans.

Daily Hospital Indemnity—this plan pays daily in-hospital benefits for Illinois Society, AAMA, members and their families regardless of age. These benefits may be paid directly to you, not the hospital, since they are paid in addition to any other hospitalization you now have.

Group Term Life Insurance—provides "pure coverage" at the lowest per dollar cost.

Living Life—this is the one plan where you don't have to become ill, injured or die to benefit from it. It builds cash value, while also providing life insurance coverage. You may convert this plan or the money that you accumulate in cash value which is yours to use as you wish.

Disability Income Plan—provides a monthly cash income when you are unable to work due to illness or accident. House or hospital confinement is never required and benefits are paid for disabilities caused by illness or accidental injury, whether job related or not.

Accidental Death & Dismemberment—is high-limit, 24 hour a day plan against loss of life due to accident.

Professional & Personal Liability Insurance—offers protection against malpractice error or negligence in the performance of your duties or injury to others, as a health care professional, for which you are liable. This includes your participation in any recreation.

The cost of coverage is low, on any of these plans, due to the buying power of the American Association of Medical Assistants and the economics of group insurance administration. You may, as a member of AAMA, enroll in any one or more of the above described plans.

For more information regarding any of the insurance plans or Illinois Society, AAMA, please contact Janet Binkowski, RN, president, 428 Adams Street, Dolton, IL 60419 or Ruby Jackson, CMA, chairman, Public Relations Committee, 7337 South Shore Dr., #625, Chicago, IL 60649. ◀

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Hepatic Porphyria

By Eugene B. Loftin, III, M.D. and Joseph F. Ruwitch, Jr., M.D./Fairfield

The authors report a hepatic porphyria with vague presentation, shock, seizures and culminating quadraparesis. Physician alertness toward this group of rare hereditary diseases is the most important step in reducing morbidity and mortality. The protean nature of this group of conditions and the danger of precipitating an acute attack with a multiplicity of commonly used drugs and procedures demands early screening with the Watson-Schwartz or Hoesch tests. Any patient with psychosis, abdominal or muscle pain, or seizure disorder should be screened prior to a trial of medication or surgery.

Genetically transmitted disorders of porphyrin synthesis have been relatively well documented since the 16th century. Through their effect on members of the great houses of Europe, most notably King George III of England, these conditions have had an important impact on our modern history.[1,2] The more temporal concern, however, is for the affected individuals who may be seen in the general practice of medicine in southern Illinois. As these conditions are frequently latent, nonspecific, easily precipitated and potentially lethal, early recognition is of utmost importance.[3] The following is a case report of such an individual with a striking clinical course.

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Case Report

A 26-year-old white woman was admitted with a five day history of diffuse abdominal pain described as "dull" and radiating to the low back. There was no associated history of dysuria, hematuria, nausea, vomiting, diarrhea, or constipation. She had been on no medications other than oral contraceptives. Her past history included a right salpingoophorectomy as a teenager due to an "ovarian cyst." Her family history was striking in that her mother died at age 23 in a "mental institution" of "meningitis" and that her grandmother died in her early 30's after "appendicitis." The patient's father stressed several times that his daughter was "acting just like her mother did before she died."

Physical examination was normal except for a temperature of 99.4F° and a low midline abdominal scar with tenderness to deep palpation in both lower quadrants without rebound phenomenon. Pelvic examination showed more tenderness in the left adnexa, but no masses.

Admitting laboratory data showed the urine with 3+ acetone, 1+ protein, 2-4 WBC/HPF and a normal CBC except for mild left shift on differential. Exploratory laparotomy was sched-

uled for the next morning and the patient was started on intravenous trimethoprim and sulfamethoxazole as she was allergic to penicillin. This drug promptly precipitated the patient's first grand mal seizure and the antibiotic was discontinued. Balanced anesthesia was used with pentothal, succylcholine, fentanyl and nitrous oxide. Findings at laparotomy were a left ovarian cyst (which was not removed) and mild adhesions (which were lysed). There was no evidence of tubal pregnancy, bleeding or infection. The patient's postoperative course was unremarkable.

Two weeks postoperatively she was seen as an outpatient and was feeling very well. Her oral contraceptive agent was continued. Approximately six weeks later she reported back to the clinic with a one week history of epigastric pain, nausea and one episode of vomiting. She was treated conservatively with propantheline bromide and antacids for probable pylorospasm. She was seen again, two months later, with recurrence of bilateral lower quadrant abdominal pain, backache and new generalized myalgias. A trial ibuprofen was ordered but she presented back to clinic two days later with more severe diffuse pain and had had a second grand mal seizure. She was readmitted to Fairfield Memorial Hospital where her blood pressure was 144/120 to 150/110. The abdominal examination was unchanged and there were no bruits. Her CBC was normal except for a slight left shift, serum BUN was 15 mg/dl, serum creatinine was 1.3mg/dl and serum sodium 130meq/L.

Tularemia is endemic to our area and the patient gave a history of having cleaned and consumed wild squirrel two weeks prior to admission. A *Francisella* tularensis titer was positive 1:160, which is considered suggestive.

Because of the patient's proximal muscle weakness, a T-4 was obtained and was 17 (normal is 4.5 to 12.0). This was discounted as due to her oral contraceptives.

The patient's new hypertension prompted an intravenous pyelogram and 24 hour urine collection for protein and creatinine were done. Both were normal.

The patient's recurrent seizures were investigated with an electro-encephalogram and computerized axial tomography of the head yielding normal results.

Phenytoin sodium, propranolol hydrochloride and tetracycline were started and the patient was discharged after seven days. The discharge diagnosis was "Typhoidal Tularemia," seizure disorder, hypertension and idiopathic hyponatremia.

The myalgias persisted but were attributed to the Tularemia. As she did not improve over ten days therapy, she was readmitted for a trial of streptomycin. On admission the phenytoin sodium level was therapeutic, serum sodium was 126meq/L, Tularemia titer was down to 1:80. Her urinalysis was normal except for 2+ acetone and 4+ urobilinogen. On the fifth hospital day the patient became disoriented and had another grand mal seizure. Eye grounds were unremarkable and deep tendon reflexes were symmetrical though decreased. A rapid check of blood sugar showed no hypoglycemia. Within a few hours the patient's blood pressure was measurably low and the patient was moved to intensive care where dopamine and rapid infusion of 5% dextrose and normal saline were the initial therapy. Because the patient's recent surgical scar was pigmented, Addison's disease was considered and intravenous steroids were given as an emergency measure. On this regimen the patient responded rapidly. The blood pressure returned to normal and then again became elevated to 150/100. Urine output and mentation returned to their previous status.

At this point the patient was considered stabilized and an endocrinologist was consulted. There, serum cortisols were normal. Studies of Vitamin B-12, folic acid, T-4, renin, 24 hour urine collections for 17 ketosteroids, aldosterone, total catacholamines, VMA metanephrine, serum and urine osmolarity and urinary excretion of sodium and potassium were all normal. This effectively ruled out Addison's disease, pheochromocytoma, hyperthyroidism, B-12 or folate neuropathy and inappropriate sodium wasting by the kidneys.

Our neurologic consultant proposed the possibility of a porphyria and a subsequent quantitative urine porphobilinogen (PBG) confirmed the diagnosis. The patient excreted 93.4mg. of PBG in 24 hours. Normal is zero to 2.0mg. Retrospectively the 4+ "urobilinogen" noted previously was most likely due to a porphobilinogen-caused color reaction.

A trial of glucose feeding was unsuccessful in changing the clinical picture as was a trial of hematin therapy which caused a mild leukopenia. However, the patient was still being exposed to valproate (a porphyrogenic drug). The patient was discharged with profound generalized muscle weakness on tetracycline, propanalol, and valproate. Subsequent to her discharge, her symptoms of diffuse pain and weakness progressed, resulting in respiratory compromise and quadraparesis. With a second trial of hematin therapy the acute episode was finally brought under control. After an intensive rehabilitation program she was finally discharged, ambulatory to a limited degree and able to do most self-care tasks.

Discussion

The porphyrias comprise six varieties of metabolic disturbances along the biosynthetic pathway to heme. All individual porphyrias are characterized by specific enzyme deficiencies leading to distinct biochemical and clinical pictures. The diagnosis of porphyria in itself is insufficient and demands further specification. In this case, porphyria cutanea tarda (PCT), which is the most common form of porphyria, could be ruled out. PCT is characterized by skin lesions, it is frequently associated with alcohol, does not give neurological symptoms, and never leads to an elevation of porphobilinogen in serum or urine. Congenital erythropoietic porphyria, an extremely rare condition, also has a characteristic photodermatitis and again is not associated with increased porphobilinogen excretion. Protoporphyria likewise has no neurologic manifestations and presents with a biochemical pattern different from the one in context.

This patient's clinical course and genetic background clearly indicates the presence of one of the three inducible porphyrias. Acute intermittent porphyria (AIP) is caused by deficiency of uroporphyrinogen I synthase, hereditary coproporphyria (HCP) by deficiency of coproporphyrinogen III oxidase, and finally, the defect in variegate porphyria (VP) is the deficiency of protoporphyrinogen IX oxidase. A detailed discussion of porphyrin chemistry is beyond the scope of this report. It is not germane to the recognition and management of the inducible porphyrias, as the presenting symptoms, diagnosis, therapy and prophylaxis are identical for all three of the inducible porphyrias. Suffice to say that acute intermittent porphyria has only neurological symptoms, whereas, the other two (HCP and VP) may also have skin manifestations.

All three inducible porphyrias present with identical acute attacks: abdominal pain, vomiting, constipation, pain in the limbs and back, tachycardia, fluctuating blood pressure, hyponatremia, seizures, motor neuropathy and neuropsychiatric problems appearing in a variety of combinations. An acute attack can be precipitated by a variety of drugs, particularly, barbiturates, anticonvulsants, estrogens and alcohol. Acute attacks can also be induced by fasting, infections, obstetrical delivery or surgery.[4] The differential diagnosis should include Guillain-Barre syndrome, psychosis of other etiology, and, as with our patient, hyperthyroidism, Addison's Disease, pheochromocytoma, tularemia, space occupying or vascular intracranial lesions, as well as drug dependence and personality disorders.[5]

Preliminary screening for the three inducible porphyrias, in particular, during an attack, should be done with either the Watson-Schwartz or Hoesch tests which involve using Ehrlich's reagent, yielding an intense red color indicating porphobilinogen in the urine.[6] This product in contrast to complexes formed with urobilinogen is not extracted with chloroform or butanol. The diagnosis and type of porphyria can firmly be established by quantitative measurements of δ-aminoevulinic acid, porphobilinogen and porphyrins in the patient's urine, and at times, in serum and stool,[7] plus enzyme test. In this patient the enzyme test of choice is for uroporphyrinogen I synthase, which can also be used to identify asymptomatic carriers.

This patient's course is instructive as it demonstrates that this relatively rare condition exists in southern Illinois. Its presentation can be dramatic and easily confused with other more common clinical conditions. No curative therapy is available, but identification of afflicted family members (half the blood relatives carry the genetic trait) and proper guidance with avoidance of inducing drugs and circumstances are highly beneficial. The Watson-Schwartz and Hoesch tests are easily done in the hospital laboratory, and it seems advisable to advocate these tests prior to surgery for abdominal pain of unknown etiology or in patients with relatives known to have porphyria. Although the proper identification of a patient and the relatives with the help of a specific enzyme test is highly desirable, this is presently only clinically feasible for acute intermittent porphyria where uroporphyrinogen I synthase, the incriminated enzyme, can be measured in red blood cells.

Treatment of a suspected acute attack can in many patients be safely accomplished with intravenous glucose at a dose of approximately 400 grams/day.[3] The physiology of this "glucose effect" is not well understood, but its usefulness is unquestioned. Hematin therapy was introduced as the treatment for an acute attack of the inducible porphyrias over 10 years ago. It is at present considered the mainstay and proved to be beneficial at least in the second course in this patient.[8] Beta blockers such as propranolol are recommended for the control of tachycardia and hypertension and seem to improve the neurologic manifestation of the disease,[9] but their effectiveness in the acute attack is questionable.[10] Thorazine may be used to safely control thought disorders, while meperidine hydrochloride is the drug of choice for pain. Management of seizures poses a problem as all major anticonvulsants are

porphyrogenic and thus have to be avoided, if at all possible.[4,5] Status epilepticus may be treated with diazepam, paraldehyde, or chloral hydrate, as well as bromides.

Comment

We present this case report to increase the "index of suspicion" for this rare disease. The incidence of hepatic porphyrias cannot be estimated due to the great proportion of latent carriers and the tendency to confuse diagnosis. Because of this, alertness toward this group of rare but important diseases can be life-saving. Certainly, patients' relatives known to have porphyria should be screened and appropriately counseled. We also suggest that patients with unexplained psychoses, abdominal pain, myalgias, hyponatremia, or seizure disorders should be screened for the presence of an inducible porphyria.

Acknowledgement

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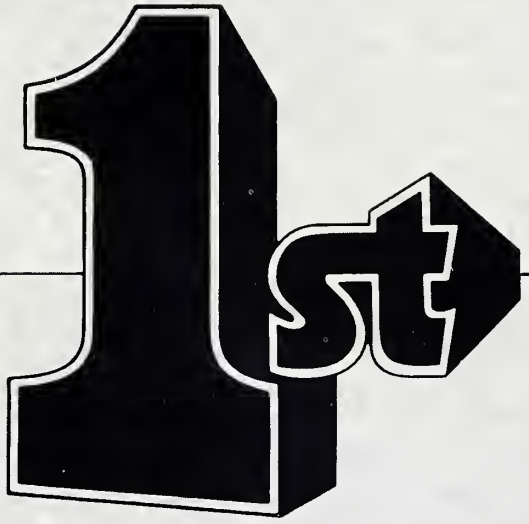
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THE MULTIVITAMIN/MINERAL FORMULATION

Possible Future Trends

Management of Glioblastoma Multiforme By Irradiation and Chemotherapy

By Wagih M. Shehata, M.D., Richard L. Meyer, M.D., Foroogh K. Jazy, M.D., John M. Tew, M.D., James M. Hall, M.D., Sr. Joseph Ignatius, M.D., Robert L. Reed, M.D. and Boleslaw H. Liwnicz, M.D./Cincinnati, Ohio

Eighty patients with the diagnosis of grade III and IV astrocytoma referred for radiation therapy were reviewed. The majority were treated by a standard whole brain irradiation (WBI) for 4,000 rad in 4-5 weeks followed by a 2,000 rad boost in two weeks. Thirty patients were also given chemotherapy. The entire group of 80 patients had a median survival of 31 weeks. However, significant ($P<0.05$) favorable prognostic factors emerged. These were: cystic lesions, radical excision, completion of $\geq$4,000 rad, grade III and favorable performance before irradiation. Those treated by chemotherapy survived longer than those without chemotherapy ($P>0.3$). Sixty-four percent of those completing $\geq$4,000 rad showed an improvement of one or two steps on a four class functional system, with a median of 27 weeks before starting to deteriorate.

We conclude that conventional radiation therapy is an effective palliative therapy which prolongs survival for an invariably fatal disease.

Glioblastoma multiforme (grade III and IV astrocytoma of the brain) is a disabling and usually fatal disease.[1,2]

The advantage of radiotherapy was known since Hyslop's report[3] in 1928. Salazar[4] showed improvements in short term survival after employing higher doses of radiation reaching the maximum tolerable levels. However, there was no sterilization of tumor cells. Other techniques including hypothermia, hyperbaric oxygen, immunotherapy, fast neutrons alone, permanent interstitial implants and preoperative radiotherapy are still considered ineffective methods of therapy. Further surgery (second look), irradiation, or chemotherapy for recurrent disease has no or little effect.

Chemotherapy, mainly nitrosourea compounds, showed some survival improvements if given with radiotherapy,[5] but if given alone the results were usually inferior to irradiation. Steroids produce some palliative effects but have not been shown to influence survival.[6]

The role of radiosensitizers and particle beam therapy in the management of this disease remains under study.

Methods and Materials

A total of 80 patients with supratentorial glioblastoma multiforme referred to the radiation oncology department over a ten year period (1969-1979) were reviewed.

Thirty-six females and 44 males with a median age of 56 years were studied. The final diagnoses were reached by biopsy (4), partial excision (50), radical excision (15) and in the remainder (11) on the basis of a CT scan and/or an angiogram finding (biopsy was considered risky). Of the total 69 patients with a definite histological proof, 27 were found to be grade III and 42 grade IV. Employing supervoltage therapy (Cobalt 60-4 MV), the majority of patients (47) completed WBI for 4,000 rad followed by a boost of 2,000 rad in a total period of 6 to 7 weeks. However, a few patients received either local brain irradiation (10 patients) or WBI (9 patients) for the entire course of therapy.

A repeat CT scan was usually performed after WBI for 4,000 rad to evaluate the response to therapy and define the small volume of boosting.

A total of 30 patients received single agent (BCNU) or multiple chemotherapeutic drugs (CCNU or Procarbazine) for 1-6 courses. Since 1975, we had utilized BCNU as a single agent. Steroids were used in 68 patients, mainly for palliation of symptoms.

Complications of Therapy

No single case of brain necrosis could be detected as the result of irradiation. One patient, a 48 year old male, developed fatal pulmonary and visceral fibrosis. He received 6,000 rads and 6 courses of BCNU each 200mgs. $\times$ 3 days every

Table 1
Performance Scale Before and After Radiotherapy (RT) for 66 Patients Who Received Minimum 4000 Rads

	I Post RT	II Post RT	III Post RT	IV Post RT
I Pre RT	3			
II Pre RT	10	13	3	
III Pre RT	3	23	4	1
IV Pre RT		1	5	

Functional Classification

I. Intellectually and physically able to work, minimal neurological changes.
II. Intellectually intact and physically able to care for himself, minimal nursing regimen, neurological findings present but not a major factor.
III. Major neurological findings requiring hospitalization, patient is responsive.
IV Morbid physical and neurological condition, completely disabled, stupor or coma—hospitalization required.

week. He survived for 45 weeks and autopsy revealed acute pulmonary edema with extensive pulmonary and visceral fibrosis.

Results

All survivals in this series were calculated from the time of actual diagnosis of glioblastoma multiforme. The entire group of 80 patients had a median survival of 31 weeks.

Of the total 66 patients who received $\geq$4,000 rad, the median survival was 36 weeks (range 12-104 weeks) with a median of 27 weeks before starting to deteriorate. Table 1 describes the functional classification before and after irradiation in those 66 patients utilizing a simple four stage system. From this table, 38 of 66 patients improved one step while another four patients improved two steps on the functional scale (64% improvements). Twenty of the 66 patients (30%) showed no change but 16 of these were in a relatively good functional state. Twenty-two of 27 patients who had repeat brain CT scan after 4,000 rad showed measurable improvement of their original lesions. In four patients the lesions were larger and in one patient there was no change.

Of the total 30 patients who received chemotherapy the median survival was 31 weeks (range 4-104 weeks) with a median of 22 weeks before starting to deteriorate.

Of the total group, ten patients are still alive (13%) with a median survival of 24 weeks. Two of these are considered NED, three currently deteriorating and the remaining five patients are considered stable. The 6, 12, 18, and 24 month actuarial survivals of the entire group were 60%, 23%, 14% and 4% respectively.

Ten patients came to autopsy; all had residual disease in the brain. Table 2 shows the favorable prognostic factors with reference to survival. All except the chemotherapy ($P>0.3$) were found to be statistically significant ($P<0.05$), after considering all variables between factors of importance. (Student's test and Welch's approximation were used when appropriate.) Among the three groups of different radiation doses, patients receiving higher doses showed a significant improvement of survival.

Discussion

From Table 2 it would appear that an important factor in survival is the ability of the patient to complete the planned radiotherapy to the brain. The 14 patients who refused or received $\leq$2,000 rad had only a median survival of nine weeks. This compares to the overall median survival of 31 weeks for the entire group. These results are similar to other published reports.[7,8] From our findings and other reports[4,7] it seems that survival could be proportionate to the total dose. Salazar,[4] employing higher doses, showed a significant ($P<0.05$) increase in the median time for recurrence of patients, particularly with grade III tumors. These higher doses of radiation did not compromise the quality of survival nor result in higher incidence of brain necrosis (nor did it improve the total survival of patients). Further increase in the total dose might result in tumor sterilization but could lead to unacceptable morbidity. It would appear at the present time that the optimum safe dose for controlling this disease by conventional photon therapy is around 5,000 rad WBI followed by 1,500 rad boost in a total period of about seven weeks. From our experience there was no statistically significant difference in survival with reference to the volume of irradiation, whether localized, WB or a combination. In our series we had only one patient with multifocal disease, and another patient with known evidence of seeding at surgery. Marsa[9] demonstrated in an autopsy series that recurrence is usually detected in the area of the primary site. Ramsey,[10] in a randomized study, showed higher survival for those treated by a localized volume of irradiation as compared to WBI, but the former group received relatively higher doses. We feel

TABLE 2 Prognostic Factors	NO. OF PATIENTS	MEDIAN SURVIVAL IN WEEKS
Cystic	11	67
Solid	69	31
Radical excision	15	38
Partial excision	50	31
R.T. dose*		
a—refused or died ≤2000 rads	14	9
b—4000-5500 rads	14	27 } 36 combined
c—6000-6500 rads	52	36 }
Grade III (6 cystic)	27	38
Grade IV (4 cystic)	42	31
No tissue diagnosis (one cystic)	11	26
Initial Function		
Class I & II	30	34
Class III & IV	50	28
Chemotherapy	30	31
No Chemotherapy	50	28

*Individual differences statistically significant ($P<0.05$)

that with improvements of local control in the dose range of 5,500 to 6,500 rad of standard photon beam, the volume of irradiation is perhaps not that crucial and local generous ports guided by CT scan could be as good as initial WBI followed by a local boost. From our series (Table 1) and others[4] radiotherapy definitely improved the performance and quality of survival of patients with glioblastoma multiforme. In our experience the median time to progression was 27 weeks for the 66 patients who received ≥4,000 rad. If one considers that our overall median survival was 31 weeks, on the average the patient seriously deteriorated only in the last four weeks of their limited life span.

Prognostic Factors

As previously mentioned, completion of radiotherapy was found to be an important prognostic factor. This is due to the aggressive nature of some of the tumors before a response to radiotherapy can be detected.[4,7] In addition, patients with good initial function (presumably less aggressive tumors) survived longer than those with initially poor function. Perhaps, initial high daily dose fractionation should be considered for those patients presenting with poor performance.[11]

From our series and others[4] grade III patients had better survival than grade IV patients. From our report and others,[4] grade IV lesions are more predominant in number. This tends to lower the median survival of the entire group. In our experience, although grade III patients survived significantly longer than grade IV patients, the two year survival of grade III patients is only 6%. Patients with grade III tumors might have a better survival than grade IV patients, partially because grade III tumors are frequently cystic. In our series, such gross cytic changes were found to be a favorable prognostic feature.

From our data and others,[12] patients with radical excision have a more favorable prognosis with reference to survival and its quality than those with partial or no excision. However, extensive surgery can possibly result in disrupted neurological function and unacceptable morbidity.[12]

In our study, age did not play a significant role in survival. However, others[4] and a recent RTOG study[13] utilizing a standard photon beam with or without chemotherapy, showed that the younger age groups tend to have a more favorable prognosis. In our series we had relatively few young patients (16 patients ≤45 years).

Chemotherapy

Our series showed a marginal improvement in

survival for those receiving chemotherapy in addition to radiotherapy (Table 2), however, these differences were not statistically significant ($P>0.3$). This is similar to results of recent published reports.[13,14] It is our feeling that since higher doses of radiation are being employed with prolongation of survival, the role of available nitrosourea compounds will probably be less significant. This also could be due to the fact that these drugs are usually administered every six weeks (due to toxicity), which might not allow for sufficient cell kill in a rapidly dividing population.

Brain Necrosis

In our series there was no single case of brain necrosis. Frank radiation-induced necrosis of normal brain tissues was not even observed in other series employing a higher radiation dose.[4] Brain necrosis is often diagnosed by exclusion[4] and it is often difficult to document. Kramer[15] after reviewing the literature 1938-1967, found only 57 patients with brain necrosis (19 of these were treated by irradiation for extracranial tumors). The incidence of brain necrosis is probably $\leq 5\%$ after 5,000 rad WBI in five weeks followed by 1,500-2,000 rad boost in 1½-2 weeks[15]. In case of multiple courses of brain irradiation for metastatic disease, brain necrosis was not observed.[6,16] However, if the treatment results of this disease improve, possibly due to higher doses of radiation use in combination with other therapeutic modalities (radiosensitizers, neutron boost) one should carefully watch for brain necrosis.

Future Trends

Particle beam therapy was tried in this disease[17,18] without improvement in survival. However a few patients showed complete sterilization of the tumor on histological examination. Perhaps because of these two studies, neutron boosting[18] after standard photon irradiation for a certain dose was considered. The final results of an RTOG protocol with fast neutron boosting are not yet available.

Radiosensitizers—A variety of drugs have been investigated as possible radiosensitizers.[19,20] Although metronidazole (Flagyl®) showed only moderate sensitizing activity, it was selected for evaluation during radiotherapy because of its low toxicity and easy diffusion. Another derivative, misonidazole[19] was found (in animal experiments) to be more effective as a radiosensitizer but it is more neurotoxic in comparison to metronidazole. Preliminary results[11] utilizing this drug with higher doses of photon irradiation (1,675-1,752 ret) did not achieve any significant improvement of overall results. These results should be compared to the best available standard approach. It remains to be seen if higher doses of radiation (possibly with conventional fractionation) in combination with radiosensitizers could improve survival.

The combination of standard photon therapy with or without a radiosensitizer (possibly with a radioprotector), or chemotherapy followed by neutron boost might be considered in future clinical trials. Hyperthermia, intra-tumoral chemotherapy, intra-arterial chemotherapy, and interstitial radiation are among the modalities that could offer future hope for the therapy of malignant brain tumors.

Such small individual gains in each modality of therapy could be additive and might improve the bleak outcome of this disease. ◀

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Tribute To A Chicago Surgeon

Ulysses Grant Dailey

By George A. Johnston, Jr., M.D./Columbus

Ulysses Grant Dailey, M.D., renowned Afro-American Chicago surgeon, attained national and international fame, while at the same time, served and promoted the welfare of the medically and socially disadvantaged. He was a citizen of Chicago during the turbulent years from 1906 to 1961. Born in 1885 in Louisiana, he was reared in Texas and came to Chicago in 1902 at the age of 17.

Dailey's brillant career in medicine began at the Northwestern University School of Medicine. He graduated with distinction in 1906 at the age of 21. In 1907 he served as physician and surgeon with the Chicago Department of Health. He received his training in surgery at Provident Hospital from the distinguished surgeon and most influencial figure in his professional life, Dr. Daniel Hale Williams. Dailey became a powerful figure in the teaching program at Provident Hospital and was respected for both his ability to communicate with patients and his surgical technique. He was among the first Afro-Americans to become a diplomate of the American Board of Surgery and fellow in both the International College of Surgeons and the American College of Surgeons.[1]

Dailey was a prolific medical author with over 50 professional and countless lay publications to his credit on a variety of general surgical and basic science topics. From 1948-1949 he served as the editor for *The Journal of the National Medical Association*.[2] Because of his polished manner and his broad appeal, his professional life was always characterized by a large surgical practice. He was fluent in several languages, including French, German and Spanish and his appeal as a physician was evident in many ethnic sectors of the city.



Ulysses Grant Dailey (1885-1961)

Dailey's international exposure began as early as 1912 when, as a young surgeon, he studied surgical techniques in Paris and Berlin. In 1951, and in 1953, under the auspices of the United States Department of State, he lectured at several universities and medical centers in Europe, Asia and Africa as a visiting surgical scholar. He was

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befriended and respected by countless foreign and American diplomats and health professionals, including, Drs. Albert Schweitzer, Charles Mayo and Chicago's Max Thorek, who was instrumental in his appointment to the board of trustees of the International College of Surgeons. He embarked on his final world tour in 1955 for the International College of Surgeons, attending medical symposia across Asia, from Tokyo to Beirut.

In all of his travels, admittedly his greatest professional challange was the delivery of health care to the masses of impoverished migrant Chicagoans during the great depression. Philosophically, he believed that well trained medical manpower and patient education were of utmost importance in combating the problems of that era.

With this in mind, he was active in a number of public outreach programs sponsored by both public and private concerns. He was instrumental in the training of numerous young physicians, many of whom practice in Chicago today, and actively recruited young talented physicians to Chicago.

Dailey's civic and professional honors were numerous. He was president of the National Medical Association in 1917, and recipient of the Distinguished Medal of Service of that organization in 1956.[3,4] He was decorated by the City of Chicago and by several governments, including Pakistan, Haiti and the United States. He was recipient of several honorary degrees from universities, including Howard University, and the Doctor of Laws from his Alma Mater, Northwestern University.

On April 22, 1961, Dr. Dailey's life ended, leaving behind a legacy of dedication and service to the international brotherhood of medical practice. ◀

Acknowledgment

My thanks to Mrs. Jan Cyrus and Mrs. Eleanor Cyrus Matthews for providing authentic historical documents regarding the life of Dr. Dailey and to Mrs. Cheryl Miller for her assistance in preparing this manuscript.

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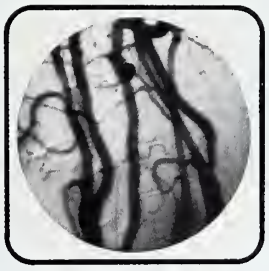
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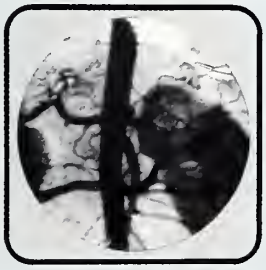
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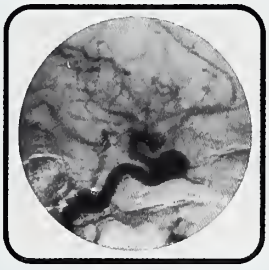
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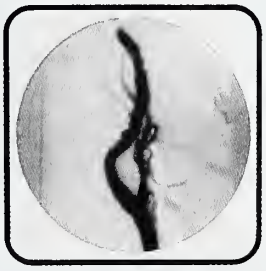
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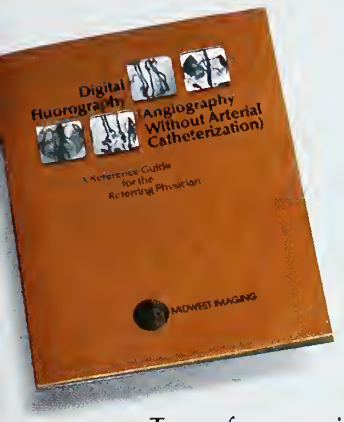


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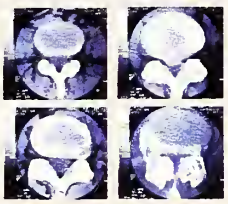
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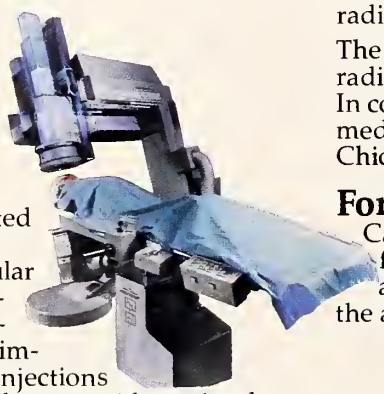
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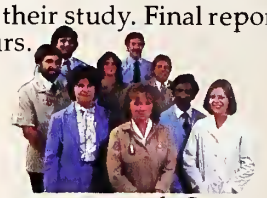
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SUMMARY OF MINUTES

1982 Interim Meeting
House of Delegates

The ISMS House of Delegates met at the Sheraton St. Louis Hotel in St. Louis, November 13-14, 1982, and took the following actions. The official minutes of the House are on file at the Illinois State Medical Society headquarters office.

OLD BUSINESS

1 (A-82)—Not Adopted
(BOT Report B)—Liability Insurance Costs
Introduced by Edwin Sinaiko, M.D.

Defeated this resolution which called upon ISMS to "seek legislation authorizing payment by the State of a percentage of an M.D.'s liability insurance costs based on the percentage of his or her time devoted to IDPA patients."

13 (A-82)—Adopted as Amended
(BOT Report C)—Monitoring UR Activities
Introduced by Fred Z. White, M.D., for the Board of Trustees

Directed the Board of Trustees and ISMS staff, where appropriate, "to carefully observe UR activities, to provide for the dissemination of appropriate information about these activities between ISMS and local physician review entities and to provide appropriate assistance upon request to local physician review entities."

23 (A-82)—Not Adopted
(BOT Report D)—Differential Reimbursement
Introduced by Eugene B. Loftin, III, M.D., for the Wayne County Medical Society

Defeated this resolution which called upon ISMS, through its appropriate councils and committees, to "develop a model reimbursement system that would be equitable."

REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

1 (I-82)—Adopted as Amended
Amendments to Chapter IX. Committees
Introduced by Robert P. Johnson, M.D., for the Board of Trustees

Amended Bylaws Chapter IX to include the: (1) Speaker of the House of Delegates, or the Vice-Speaker in his absence, as ex-officio members of the Executive Committee without vote; and (2) CME Accreditation Appeals Panel as a Board of Trustees Committee.

2 (I-82)—Adopted
ISMS Policy Statement on "Hospitals"
Introduced by John J. Ring, M.D., for the Board of Trustees

Directed that the policy statement on "Hos-

pitals" be modified and divided as follows:

HOSPITAL AND MEDICAL STAFF COMMITTEES

A hospital's medical staff should be an autonomous, self governing body whose members participate in the activities of medical staff and hospital committees. However, physicians should distinguish between committees where the hospital gives the staff authority and responsibility and those where the hospital has full responsibility. Medical staff committees should be those composed solely of members of the medical staff and concerned with the quality of medical care. Hospital Committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, that may or may not include medical staff members.

MEDICAL STAFF PARTICIPATION IN ACCREDITATION ACTIVITIES

Medical staff of a hospital should cooperate to achieve the accreditation of their hospital.

MEDICAL STAFF PARTICIPATION IN HOSPITAL COST CONTAINMENT EFFORTS

Physicians on a hospital's medical staff should encourage and cooperate in efforts to see that hospital care is delivered in the most cost effective manner without compromising quality.

MEDICAL STAFF RELATIONSHIP WITH COUNTY MEDICAL SOCIETY

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health related agencies in their community.

3 (I-82)—Adopted
Amendment of Policy Manual Statement on "Informing the Membership"

Introduced by Cyril C. Wiggishoff, M.D., for the Board of Trustees

Directed that the policy statement on "Informing the Membership" be amended as follows:

2. "Brief notice in Action Report, whenever possible, outlining the issue and calling attention to the IMJ article; and"

18 (I-82)—Referred to Board
Strengthening Peer Review
Introduced by Albert W. Ray, Jr., M.D., for the Will-Grundy County Medical Society

Referred to Board of Trustees for study a proposal that the "ISMS bylaws be changed so as to require that its members be enrolled in that county society wherein lies the major portion of their practice."

21 (I-82)—Adopted as Amended
Use of the Term "Physicians"
Introduced by William P. Gibbons, M.D., for the DuPage County Medical Society

Directed that the Society: (1) Reaffirm the Policy defining "physicians": The term "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches"; (2) Urge the AMA to make this definition of a physician part of its official policy; and (3) Participate in the comment period regarding proposed Department of Health and Human Services regulations which would broaden the term physician.

Substitute 25 (I-82)—Adopted
Necessity for Interim Meeting
Introduced by Joseph C. Sherrick, M.D., Third District Trustee

Directed that the ISMS Bylaws be amended so that an Interim Meeting shall occur only if called by the Board of Trustees; and that these Bylaws changes be submitted to the House of Delegates at the 1983 Annual Meeting for approval.

REFERENCE COMMITTEE A

4 (I-82)—Adopted
AMA Section for Hospital Medical Staffs
Introduced by Robert P. Johnson, M.D., for the Board of Trustees

Directed that the Society oppose AMA Board

of Trustees Report E (A-82) entitled "Hospital Medical Staff Membership in the AMA," which calls for the creation of a section on hospital medical staffs eligible to elect a delegate and alternate delegate to the AMA House of Delegates.

Also directed that this position be forwarded to the AMA through our delegation to the AMA.

5 (I-82)—Adopted as Amended
Hospital Medical Staff Appointments and Privileges
Introduced by Donald W. Aaronson, M.D.

Directed that the Society: (1) Establish the policy that physicians whose medical staff appointments are terminated or whose hospital privileges are reduced are entitled to a process based upon reasonable criteria, including the opportunity for an impartial hearing; and (2) Introduce appropriate legislation or seek other avenues to ensure that physicians' constitutional rights to substantive and procedural due process are protected.

6 (I-82)—Referred to Board
Enactment of Legislation to Provide for Substituted Consent
Introduced by Donald W. Aaronson, M.D.

Referred to the Board for study a proposal that the ISMS recommends legislation be enacted providing that consent for furnishing medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.

In addition, the House authorized that the Board be allowed to implement any appropriate legislation during the next session of the Illinois General Assembly.

7 (I-82)—Referred to Board
Modifying Mandatory Reporting Legislation
Introduced by Samuel J. Schimel, M.D.

Referred to the Board for study a proposal that the Board make every effort to modify the present enacted legislation (Senate Bill 1614). The proposal further directs that: (1) Requirement that a hospital notify the Illinois Disciplinary Board of any minor action taken against a hospital staff physician should be deleted; and (2) A malpractice insurance company should not be required to notify the Disciplinary Board of every malpractice suit until after the local society investigates the physician and find him to be negligent.

10 (I-82)—Adopted as Amended
Malpractice Crisis
Introduced by William B. Frymark, M.D., for the DuPage County Medical Society

Directed that the Society, through its various councils, continue to propose and actively support legislation and other activities necessary to prevent another malpractice crisis in Illinois.

15 (I-82)—Not Adopted
Claims Made Insurance
Introduced by Edwin Sinaiko, M.D.

Defeated this resolution which called upon the Society to request that the "Illinois State Medical Inter-Insurance Exchange consider the possibility of offering the claims made form of professional liability insurance."

27 (I-82)—Not Adopted
Public Aid Recipients in HMOs
Introduced by Samuel J. Schimel, M.D.

Defeated this resolution which called upon the Society to make every effort to stop the registration of public aid recipients in HMOs and promote legislation in the Illinois General Assembly to prevent this socialization of medical practice.

28 (I-82)—Adopted as Amended
Minimum Professional Liability Coverage
Introduced by David S. Fox, M.D.

Endorsed the principle that "the hospital medical staff and only the medical staff should establish minimum limits of professional liability insurance coverage for their own medical staff."

Reports
Report A of the Board of Trustees was filed for information.

REFERENCE COMMITTEE B

8 (I-82)—Adopted as Amended
Health Planning
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Directed that the Society: (1) Vigorously oppose the proposed merger of the Chicago,

Suburban Cook-DuPage and Kane-Lake-McHenry Health Systems Agencies; and (2) Give strong support to any legislation which supports voluntary health planning without regulations and separates Certificate of Need from the planning process.

Substitute 9 (I-82)—Adopted as Editorially Amended
Block Grants
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Directed that the Society "support the concept that when federal funds are available to the states, physicians should actively participate in the development of priorities for the distribution of these funds.

11 (I-82)—Adopted
Health Care Coalitions
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Directed that the Society "urge the American Medical Association to define 'health care coalitions' in order to assure physician participation."

12 (I-82)—Adopted as Amended
In-flight Medical Supplies
Introduced by Raymond A. Dieter, M.D., for the DuPage County Medical Society

Directed that the Society encourage "the Air Travel Association to instruct air carriers to equip planes with an emergency kit on each flight and that flight crews be instructed in CPR procedures."

13 (I-82)—Not Adopted
Chiropractic
Introduced by Raymond A. Dieter, M.D., for the DuPage County Medical Society

Defeated this resolution which called upon the Society, through its Council on Governmental Affairs, to "propose and actively support legislation to further restrict chiropractors who are expanding into areas in which they are not qualified."

14 (I-82)—Adopted
Comparability of Medical Education
Introduced by Robert P. Johnson, M.D., for the Board of Trustees

Directed that the Society: (1) Support the philosophy that all medical education accepted for license to practice should be comparable; and (2) Communicate this support to the AMA and the Illinois Medical Examining Committee as they continue to support quality medical education.

Substitute 16 (I-82)—Adopted as Editorially Amended
Accreditation for Continuing Medical Education
Introduced by Ronald G. Welch, M.D., for the St. Clair County Medical Society

Directed that the Society: (1) Review and, if necessary, revise the ICCME guidelines to be certain that CME accreditation rules are uniformly and consistently applied; and (2) Increase the role of ICCME as a facilitator in developing CME programs in Illinois communities.

17 (I-82)—Adopted as Amended
National Library of Medicine
Introduced by John J. Ring, M.D., First District Trustee

Directed that: (1) It shall be the policy of the Illinois State Medical Society to support the programs of the National Library of Medicine; (2) Fees for subscribers be based on the current accounting system rather than on total costs; and (3) A similar resolution be introduced into the AMA House of Delegates.

19 (I-82)—Adopted as Editorially Amended
ISMS Student Loan Fund
Introduced by David Whitney, M.D., for the ISMS/RPS and Malcolm Major for the ISMS/MSS

Directed that: (1) The members of the ISMS Board of Trustees and the Task Force on Financial Aid to Medical Students be commended for the creation of the Illinois State Medical Society Student Loan Fund; and (2) The Society contact other state medical societies offering them information on instituting similar loan funds in their states.

20 (I-82)—Adopted as Amended
Seatbelt Use
Introduced by Malcolm Major, for the ISMS/MSS

Directed that the Society: (1) Publish information in the *Illinois Medical Journal* concerning the efficacy of seatbelt use in reducing injury in motor vehicle accidents; and (2) Policy support the voluntary use of seatbelts and other passenger restraint devices as effective methods of reducing injury and death in motor vehicle accidents.

23 (I-82)—Adopted as Editorially Amended
HMO Client Identity Card
Introduced by Michael Treister, M.D., for the Chicago Medical Society

Directed that the Society meet with the Department of Insurance and urge that the Department institute the following policy: "Every insurance identification card for an HMO must have the words 'HMO' clearly printed on the front of the insurance card, along with the warning that unauthorized services may not be reimbursed and along with a 24 hour telephone number which can be called for payment approval in the event of emergency."

24 (I-82)—Adopted as Editorially Amended
Medical Care to the Unemployed
Introduced by Fred Z. White, M.D., for the Board of Trustees

Directed that the Society reaffirm organized medicine's commitment to provide care to those who need medical care, regardless of their ability to pay for medical care.

26 (I-82)—Adopted
Continuing Medical Education Audits
Introduced by Joseph B. Perez, M.D., Twelfth District Trustee, for the Winnebago County Medical Society

Directed that the Society adopt the following position with the Department of Registration and Education: "That the notification by the Department of Registration and Education to a physician who is to be audited for Continuing Medical Education credits for the purpose of relicensure should be sent by the Department of Registration and Education to the physician by certified mail."

MEMORIAL RESOLUTIONS

The House also adopted memorial resolutions in memory of Drs. Murray C. Brown, Chicago, and Merle D. Swearingen, Lacon, and expressed its profound loss and condolences to their families.

RESOLUTION WITHDRAWN

The following resolution was withdrawn by its sponsor prior to consideration by the House:

Res. 22 (I-82)
House Parliamentary Procedures.
Introduced by Lorris M. Bowers, M.D. for the Peoria Medical Society

ATTENDANCE

The Credentials Committee recorded attendance of the 1982 Interim House of Delegates as follows:

	First Session	Second Session
Officers & Trustees	26	24
Speaker & Vice Speaker	2	2
District 1	8	8
District 2	2	2
District 3	68	68
District 4	13	14
District 5	7	7
District 6	5	5
District 7	2	2
District 8	6	8
District 9	6	4
District 10	6	5
District 11	15	15
District 12	8	8
Intern/ Resident	0	1
Student	1	2
TOTAL	175	175

The Cook County Graduate School of Medicine
CONTINUING MEDICAL EDUCATION
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March-May 1983

Fiberoptic Esophagogastric Endoscopy
March 7-9
Current Concepts in Pediatric Pulmonary Disease
March 7-9
Specialty Review in Psychiatry
March 14-18
State and National Board Review: Basic
March 21-27
State and National Board Review: Clinical
March 28-April 2
Specialty Review in Anatomic Pathology
April 11-16
Specialty Review in Clinical Pathology
April 18-22
Flexible Fiberoptic Sigmoidoscopy
April 23
Specialty Review in Urology
April 25-30
Specialty Review in Radiology
April 25-29
Fiberoptic Colonoscopy
April 27-29
Specialty Review in Anesthesiology
May 1-6
Fiberoptic Esophagogastric Endoscopy
May 2-4
Advances in Surgery
May 2-6
Specialty Review in Obstetrics and Gynecology, Part I
May 16-21
Principles of GI Endoscopy
May 18-20
Specialty Review in Orthopedics
May 22-28
Specialty Review in Family Practice
May 31-June 11

For further information write or call:
The Cook County Graduate School of Medicine
707 South Wood Street
Chicago, Illinois 60612
(312) 733-2800

Board Abstracts

(Continued from page 18)

National Board of Medical Examiners Certificate. The new mechanism would provide the means to achieve licensure in any jurisdiction. Several groups have been opposed to this as it usurps the prerogatives of medical schools, it provides no alternatives, it could lead to licensure by specialty or national licensure, and the present system has worked satisfactorily.

Based on this review, the Board agreed not to support the new proposed FLEX system and to communicate these concerns to the Federation of State Medical Boards (FSMB). In addition, the Board agreed to urge the FSMB to work with the organizations of the Accreditation Council for Graduate Medical Education to bring about a pathway to medical licensure which will satisfactorily insure that physicians who practice medicine are qualified to do so.

EMERGENCY MEDICAL SERVICES

Proposals have been made by IDPH that legislation be introduced to amend existing emergency medical services law to remove jurisdiction of Intermediate Life Support Services for trauma centers. The proposals do not allow for appropriate supervision of EMS activities. In review of this the Board adopted the following statement concerning emergency medical services and directed that this position be communicated to the Illinois Department of Public Health:

> "Emergency medical services which employ non-physician personnel and carry the risk of major complications should be under the supervision of a physician licensed to practice medicine in all its branches knowledgeable of emergency medicine, and a resource hospital responsible for the control of such a system."

EDS-FEDERAL

Upon review of experience with EDS-Federal, the Medicare intermediary for Illinois, the Board identified that many problems have been resolved over the recent years. The agency has attempted to be responsive when specific concerns have been identified. Start up difficulties of several years ago have been substantially corrected, although ongoing negotiations are aimed at some still present difficulties. As HCFA is conducting bidding on a new contract for an Illinois Medicare carrier, the Board was concerned that any change of carrier could cause turnover problems which would swamp the Medicare system. The Board directed that ISMS renew its previous endorsement of EDS-Federal as the Medicare Part B carrier in Illinois, contingent upon review and future resolution of remaining areas of concern.

COMMITTEE ON DRUGS AND THERAPEUTICS

Acting on recommendations from the Committee on Drugs and Therapeutics, the Board voted to:

- Recommend inclusion of the following drugs in the IDPA Drug Manual: Haloperidol 20 mg. tablet (Haldol); Malathion 0.5% lotion (Prioderm); Methyl Phenidate 20 mg. (Ritalin-SR); Procainamide 750 mg. (Procan-SR); Aspirin 975 mg. (Easprin); Acetaminophen 80 mg./0.8ml (Tylenol) and Zomepirac Sodium 100 mg. (Zomax).
- Recommend the following drugs not be included in the IDPA Drug Manual: Diflunisal 350 mg. and 500 mg. (Dolobid); Synalgos-DC and Diazepam 15 mg. (Valrelease).
- Recommend removal of Maxigesix capsules, Codeine Phosphate injection, Meperidine HCL tablets, Morphine Sulphate tablets, Nisentil injection, Numorphan injection, Pantopon injection, Sublimaze injection, Talwin injection and tablets, Tylox capsules, Vicodin tablets, Terpin Hydrate Elixir, Terpin Hydrate with Dextromethorphan Elixir, Terpin Hydrate with Codeine Elixir and Acetaminophen 60 mg./0.6 drops from the IDPA Drug Manual.
- Recommend that Gunaifenesin with Dextromethorphan expectorant and Bronkosol be restored to the IDPA Drug Manual.

PEER REVIEW APPEALS

The Board received a report reviewing recent legal opinions from the U.S. Supreme Court and

the Federal Trade Commission on the subjects of peer review and fee adjudication. It was legal counsel's opinion that the U.S. Supreme Court upheld voluntary, advisory peer review as entirely legal. Specific criteria were also laid out by the FTC, which, if followed, would allow activity non-violative of anti-trust laws. Counsel indicated that peer review mechanisms structured in accordance with these guidelines should withstand legal challenge, so long as the process does not result in collusive standardization or fixing of fees.

As a result of this review, the Board directed that information contained in the ISMS Legal Counsel's opinions regarding the FTC parameters for peer review committees be disseminated to component medical societies for their information.

ILLINOIS ACADEMY OF PHYSICIANS' ASSISTANTS

At the June 26, 1982, meeting, the Board agreed to discontinue the staffing and related activities currently being provided to the Physicians' Assistants as of December 31, 1982.

The Board reconsidered this action and voted to offer the Physicians' Assistants:

- A pricing of the services they request of ISMS, and
- A liaison relationship to ISMS.

OTHER ACTIONS

In addressing various other issues, the Board:

- Referred the Impartial Medical Testimony and Worker's Compensation Rosters to the Medical Legal Council for an in-depth evaluation of possible restructuring.
- Directed that the Medical Legal Council, working within the medical disciplinary procedures of the new mandatory reporting law, study various methods of being cooperative with the Medical Disciplinary Board in providing appropriate review activities.
- Approved a Hold Harmless Agreements statement for distribution to county medical societies.
- Authorized staff to work with the Health Care Service Corporation to make the PROBE presentation available to county medical societies on request.
- Directed that the AMA Delegation's effectiveness, selection process and tenure of delegation members, be evaluated by an Ad Hoc Committee consisting of three members of the Board along with the AMA Delegation; and, further, full consideration be given to qualified students or residents who may be considered for election when an opening is available on the delegation.

  The Board subsequently recommended that this decision be referred to the Policy Committee for study and recommendation.
- Directed that the status of diploma nurse programs, accreditation, transfer of credit to baccalaureate programs and related areas of concern which might alleviate the nursing shortage in Illinois, be referred to the Task Force on Allied Health.
- Referred to the Council on Medical Services a request from the Illinois Continuity of Care Organization to endorse their 1983 Annual Meeting Workshop. The Board directed that the Council research the Continuity of Care Organization and report back their findings in regard to endorsement of the program.
- Directed that a task force composed of ISMS and Illinois State Bar Association (ISBA) members be created under the Medical Legal Council to discuss the medical liability problem, with a focus on physician-attorney relationships, and to recommend to both parent organizations actions to resolve identified problem areas.
- Directed that ISMS send letters to the Directors of IDPH and R&E informing them of our interest in having a state reference book on laws impacting medical practice, and proposing a joint meeting of the two departments, ISMS and ISBA to discuss the scope, format, distribution and cost of this project.
- Directed a communication to the Illinois Board of Education emphasizing the importance of retaining current health education mandates for the benefit of Illinois students.
- Directed that: (1) The report entitled, "Free Standing Emergency Centers in Illinois" be distributed to the membership through the *Illinois Medical Journal* to

fulfill the directives of ISMS substitute Resolution 43 (A-81); and (2) A continuing ongoing evaluation be done by the Council on Medical Services.

- Approved revisions in the ISMS sponsored membership Major Medical Program, and a new ISMS sponsored membership Medicare Supplement Program.
- Directed that the ISMS Delegation to the AMA respond to an American Academy of Neurology resolution by: (1) Supporting the concept of reimbursement by third party payors for procedures performed in medically appropriate settings when quality control and UR mechanisms are set in place; and (2) Neither supporting nor opposing the issue of differential reimbursement on the basis of medical specialty pending a decision by the courts in the Michigan *AAFP* vs. *Michigan Medicare Carrier* appeal.
- Referred consideration of nomination mechanisms for appointments to AMA Councils to the Policy Committee for review and recommendation.

PROGRAM SPONSORSHIP

- Agreed: (1) To co-sponsor, in name only, a sports medicine program designed for wrestling coaches on nutritional issues in association with IDPH, the University of Illinois, the Illinois State Council on Nutrition and the Center for Athletic Injury and Research; and (2) To appoint Ed Grogg, M.D., as the ISMS representative to the program.
- Approved development of a program and materials for county societies on peer review and disciplinary issues, which can be offered on a regional basis to interested parties one or more times in 1983.
- Granted approval to the Resident Physicians Section to sponsor a two-day workshop on Practice Management in January or February, 1983. The program would be held at ISMS headquarters and would be self-supporting through registration fees of $95 for members and $125 for non-members. The workshop is contingent upon the RPS determining that there are no competing programs being scheduled that might cause registration to be inadequate.

APPOINTMENTS AND NOMINATIONS

Acting upon recommendations of the Councils and Executive Committee, the Board:

- Approved submission of the following physicians as nominees for appointment to the IDPA's State Medical Advisory Committee: Drs. Michael Carbon, Carol Stream; Audley F. Connor, Jr., Chicago; Roger DeCook, Downers Grove; Randolph Emerson, Decatur; Charles Frazer, East St. Louis; Robert R. Hartman, Jacksonville; Donald Hoard, Chicago; Boyd E. McCracken, Jr., Greenville; George T. Mitchell, Marshall; Robert Muehrcke, Oak Park; Paul Norris, Peoria; Pedro Poma, Chicago; Jacob E. Reisch, Springfield; Dennis Reter, Canton; Claire Sledge, Cairo; Arthur R. Traugott, Urbana; Hugo Velarde, Chicago and Fred Z. White, Chillicothe.
- Ratified the appointment of Dr. E. Richard Blonsky, Chicago, to the Worker's Compensation Committee.

In addition, changes in committee organization were acted upon as follows:

- Discharged the Jail Health Program State Technical Advisory Committee.
- Placed the Sports Medicine and Laboratory Services Committees under the Council on Medical Services.
- Made the Panel for the Impaired Physician a free standing direct reporting "Committee for the Impaired Physician" with liaison to the Membership Services Task Force and the Council on Mental Health and Addiction. In addition, the Board directed that the Committee's reports to the Board be made in Executive Session.
- Directed that the Committee on Committees be available to assist the Board chairman in reviewing appointments to ISMS councils, committees and related entities.
- Approved: (1) Guidelines for the Establishment of a Blood Banking Steering Committee; and (2) Establishment of the committee as an advisory group to the Committee on Laboratory Services. ◀

Doctor's News

BLOOD DONOR MONTH—January has been declared National Volunteer Blood Donor Month by President Reagan. According to the American Blood Commission, a national group of leading medical and consumer organizations dedicated to insuring that adequate blood donor supplies are maintained, over 95% of all Americans reaching age 72 will need blood or one of its by-products.

PHYSICIANS IN THE NEWS—Two St. James Hospital physicians, **Steven Horowitz, M.D.** and **Doda Narayana, M.D.**, both of Chicago Heights, were named fellows of the American College of Surgeons.

Physicians recently elected to fellowship in the American College of Physicians (ACP) will be honored at the annual session in San Francisco, April 11-14, 1983. The Illinois physicians elected to fellowship are: **Melvin K. Roseman, M.D.**, Highland Park; **Massih Hakami, M.D.**, **Muhammed Z. Iqbal, M.D.**, **James J. Mathews, M.D.** and **Amjad I. Sheikh, M.D.**, all of Chicago; **Patrick J. Scanlon M.D.**, Glen Ellyn; **Cary E. Berfkowitz, M.D.**, Glenview; **Tien C. Cheng, M.D.**, Gurnee; **David S. Ginsburg, M.D.**, Highland Park; **Edwin J. Zarling, M.D.** Hinsdale; **Donal W. Dixon, M.D.** Maywood; **Leonard J. Hertko, M.D.**, Palos Heights; **Terry L. Ostrowski, M.D.**, and **G.W. White, M.D.**, both of Park Ridge; and **Peter J. Geiseler, M.D.**, Wilmette.

Twenty-five Illinois physicians attained fellowship status in the American College of Chest Physicians during 1982. The new fellows of this 11,000 member international, multi-disciplinary, organization are: **Larry E. Alves, M.D.**, Belleville; **Michael G. Ankin, M.D.**, Wilmette; **Arthur S. Banner, M.D.**, Wilmette; **Jayant C. Bhalerao, M.D.**, Galesburg; **Robert A. Bielinski, M.D.**, Des Plaines; **Michele A. Codini, M.D.**, River Forest; **Nicholas M. DiFilippo, D.O.**, Brookfield; **Patrick J. Fahey, M.D.**, Maywood; **Lt. David E. Fisk USAF MC**, O'Fallon; **Stuart Frank, M.D.**, Springfield; **David C. Hueter, M.D.**, Winnetka; **John G. Kelsey, M.D.**, Chicago; **Kyung W. Koo, M.D.**, Elgin; **Yukol Lertsburapa, M.D.**, Hinsdale; **Dionisio R. Marucut, Jr., M.D.**, Oak Brook; **Evan G. McLeod, M.D.**, Chicago; **Terrance C. Moisan, M.D.**, Palos Heights; **Theeragul Moraras, M.D.**, Evanston; **Manoocher Nassery, M.D.**, Quincy; **Rajindar Singh, M.D.**, North Chicago; **James M. Wicks, M.D.**, Lake Forest; **Jeffrey A. Wolfson, M.D.**, Aurora; and **Ralph S. Zitnik, M.D.**, Evergreen Park.

DRUG-USE INFORMATION BOOK—The United States Pharmacopeia (USP) has updated and revised *About Your Medicines,* a drug-use information book for consumers. *About Your Medicines* contains monographs for over 400 drugs or combinations, offering information on proper use, side effects, precautions, interactions, and storage. Consumers can purchase *About Your Medicines* at pharmacies and other health care facilities. USP offers other educational materials including *Advice for the Patient,* a complete reference book on drug substances used in medicines in the United States.

For more information on USP and its programs, contact the USP Drug Information Division, 12601 Twinbrook Parkway, Rockville, MD 20852 or call (301) 881-0666.

IAFP ANNUAL MEETING DATE SET—The Illinois Academy of Family Physicians has announced that the next annual meeting will be held May 22-26, 1983, at the Pheasant Run Lodge, St. Charles, Illinois. Further information may be obtained by contacting H. Marchmont-Robinson, M.D., executive director, 1200 Harger Road, Suite 405, Oak Brook IL 60521.

CLINICAL PATHOLOGY FORUM—Pathologists, pathology students, and other laboratory professionals are invited to exchange information on anatomic and clinical pathology and laboratory medicine in a forum sponsored by the American Society of Clinical Pathologists. All materials must be submitted by June 15, 1983. The papers and posters will be presented at the ASCP/CAP Fall National Meeting in St. Louis, Missouri, October 14-22, 1983.

For guidelines and abstract submission forms contact: ASCP Manager for Scientific Assemblies, 2100 West Harrison, Chicago, Illinois 60612 or call (312) 738-1336, ext. 185.

EDUCATIONAL MATERIALS ON HYPERTENSION—Pamphlets and audiovisual materials on the control of high blood pressure are available free of charge from the National Heart, Lung and Blood Institute of the National Institutes of Health, according to a recent *AAFP Reporter.*

For order forms, physicians should write to the High Blood Pressure Information Center, 120/80 National Institutes of Health, Bethesda, MD 20205 or call (701) 558-4800.

REVERSING STROKES—A therapeutic technique to reverse a stroke before it has completely choked off blood to a region in the brain has been found effective in eight of nine patients in a preliminary clinical study. According to a recent AMA News Release, the study traces improvement in patients who were experiencing partial paralysis or loss of speech. The authors suggest that the dilution technique improves the flow of blood to the deprived area of the brain through collateral blood vessels. The preliminary study did not include a control group.

ISMS PLANS PROGRAMS AT CMS MIDWEST CLINICAL CONFERENCE—ISMS will conduct two programs at the Chicago Medical Society Midwest Clinical Conference, March 18-20 at the Chicago Conrad Hilton. "Sports Medicine," is the title of a program planned by the ISMS Sports Medicine Committee for Saturday, March 19. "Evaluation and Treatment of Pain and Disability," will be coordinated by the ISMS Committee on Worker's Compensation and scheduled for Friday, March 18.

The Sports Medicine Program will be coordinated by H. Bates Noble, M.D., chairman of the ISMS Sports Medicine Committee and will include "Practical Rehabilitation of Athletic Injuries" (Robert Hamilton, M.D.); "Use of Ergogenic Aids in Athletics" (Jacob R. Suker, M.D.); and "Nutrition in Athletics" (Richard B. Parr, Ed.D.).

The ISMS Workers Compensation Committee's program, "Evaluation and Treatment of Pain and Disability" will also be hosted by its chairman, Eugene Rogers, M.D., F.A.C.P., and will include the following topics: "Rehabilitation, Evaluation and Treatment of Pain and Disability" (Eugene Rogers, M.D.); "Neurological Evaluation and Treatment of Pain Syndromes" and "Work Evaluations" (E. Richard Blonsky, M.D.); and "Industrial Commission of Illinois—Physician Roles and Responsibilities" (Georgianne Riley, Industrial Commission legal counsel). This program is planned in cooperation with the Chicago Society of Physical Medicine and Rehabilitation.

Both programs will earn Category 1, CME credit and are suitable for physicians with medical specialties which directly utilize program information or physicians with general interest in the issues to be presented.

Neil Solomon, M. D., Ph. D.

Dear Colleagues:

Thank you for the thousands of inquiries I received concerning your interest in my Cigarette Smoking Elimination Program. I must apologize for the delay in my response; however, I wanted personally to make sure that this procedure had clinical merit.

Based on my clinical series, I feel that we, the medical community, should look upon this method, not as a cure-all, but as something positive that can be done to assist our patients.

Data from my clinical series, over a three year period, and data from other physicians, showed similar results. From a combined patient pool of several thousand, we observed approximately 85% of the patients stopped smoking completely for the first month. This was based on the data we received from questionnaires returned by patients. Approximately 50% remained non-smokers for up to and including three years.

This procedure is performed in one office visit. The visit usually takes 1½ hours to 2 hours. It includes: history, physical examination, Pulmonary Function Tests, EKG, blood test, urinalysis, the injection, behavioral modification tips, and a smoker's diet that I conceived. I have noticed that for optimal results, the patient must be highly motivated to want to stop smoking.

The usual and customary fee I charge patients for the aforementioned is $385.00. Their sincere willingness to pay this amount adds to their commitment.

It would be impossible for me, using this form, to go into great detail concerning this comprehensive method. It is for that reason that I, through **Consultants in Medical Education,** have agreed to lecture to interested physicians who desire to use it.

It disturbed me greatly that as a result of the positive coverage in the lay press, including glowing testimonials from successful patients, a few, solely profit-oriented individuals, have made great personal fortunes by offering their own "lay" brand of this procedure. I feel a responsibility to the millions of cigarette smokers who desperately want to quit. I also feel a responsibility to share with my colleagues the details of this procedure.

If you desire further information concerning this program, please direct all correspondence to **Consultants in Medical Education** at:

Post Office Box 21371
Pikesville, Maryland 21208;

or call **301/472-4263.**

Sincerely,

Neil Solomon M.D.

Neil Solomon, M.D., Ph.D.

Pulse of the ISMS Auxiliary

Are You Aware . . .

Teenage Pregnancy

By Diane Hinderliter, ISMSA President

Is teenage pregnancy a major problem in this country? Is there a pregnancy explosion among single teens? What about the teenage mothers who make up the statistics? Hardly a week goes by without some reference to teenage pregnancy on television, radio, or in the newspaper.

In October 1980, the Illinois Department of Public Health created and appointed the Statewide Task Force on Adolescent Support Services. From October 1980 through April 1982, the Task Force met every other month to begin to develop a framework for addressing the myriad problems associated with teenage pregnancy and parenthood. "Nearly one in ten women between the ages of fifteen and nineteen becomes pregnant in Illinois each year," according to the Task Force. "More than half of the births to teenagers occur to unmarried adolescents."[1] In the City of Chicago alone, 8900 teens under the age of nineteen were pregnant last year. Only 2000 were seen prior to delivery for any kind of prenatal care.

The implications of teenage pregnancy are alarming. There are the known obstetrical risks, some of which include anemia, pre-eclampsia, eclampsia, premature labor, cephalopelvic disproportion, and others. For the fetus, there is increased incidence of low birthweight, increased mortality, and prematurity.

The most common cause for school dropout among female adolescents is pregnancy. "Four-fifths of the adolescents in the U.S. who become mothers by age seventeen will never complete high school and are twice as likely to live in poverty, be unemployed, and dependent on welfare."[2] Since approximately 90% of all adolescent mothers in the United States keep their babies, this presents an economic problem since teens have neither an education nor means of support.

Dr. James F. Jekel of Yale University has stated, "Most of the teenagers I have spoken to and heard about emphasize that they got pregnant because they wanted to have someone to love and to love them."[3] Many of these young girls have not had love and attention at home. For them the baby becomes the focus of love and the central purpose of their life. However, an infant is hardly able to give them the love they need and have missed from their own family. After taking care of the child for approximately one year the child becomes a burden. "Life at home becomes confining and unpleasant-especially if the teenager is living alone, with no companion but the infant, or with a mother who is trying to impose her own standards of child-raising."[4]

So, now that we are aware of some of the statistics about teenage pregnancy, what can we as auxilians do? How can we effectively intervene? First, find out about the sex education offered in your school system. If you have teenagers be sure you are communicating with them and know what is happening in their lives. If you have a county health department check with them to see what information they have available on teenage pregnancy. There are also other good sources that vary in each community. If you can, take the information from your reputable community source, whether it be your county society, health department or project bank, to the school and see that it is made available to the teenage population. This is the first step. This information needs to be thoroughly discussed, not just passed out and superficially mentioned.

Some cities across the United States are offering Drop-In Centers for young and unmarried moth-

ers. These centers offer counseling, social service connections, and information designed to meet the needs of these young women. Some counsel teenage fathers as well, since many of them are confused and frightened also. These centers are staffed with professionals, but many accept help of volunteers. Here is another possible area of personal involvement.

By no means am I trying to imply that the suggestions offered will eradicate teenage pregnancy if you follow a few simple steps. This is an alarming problem that will not be eliminated overnight, but with hard work and diligence, we as auxilians can, at least, *help* make a difference. ◀

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THE PROBLEM

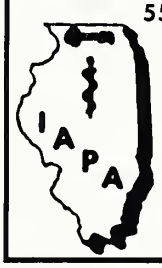
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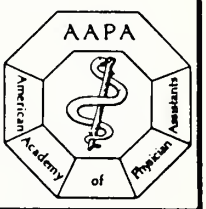
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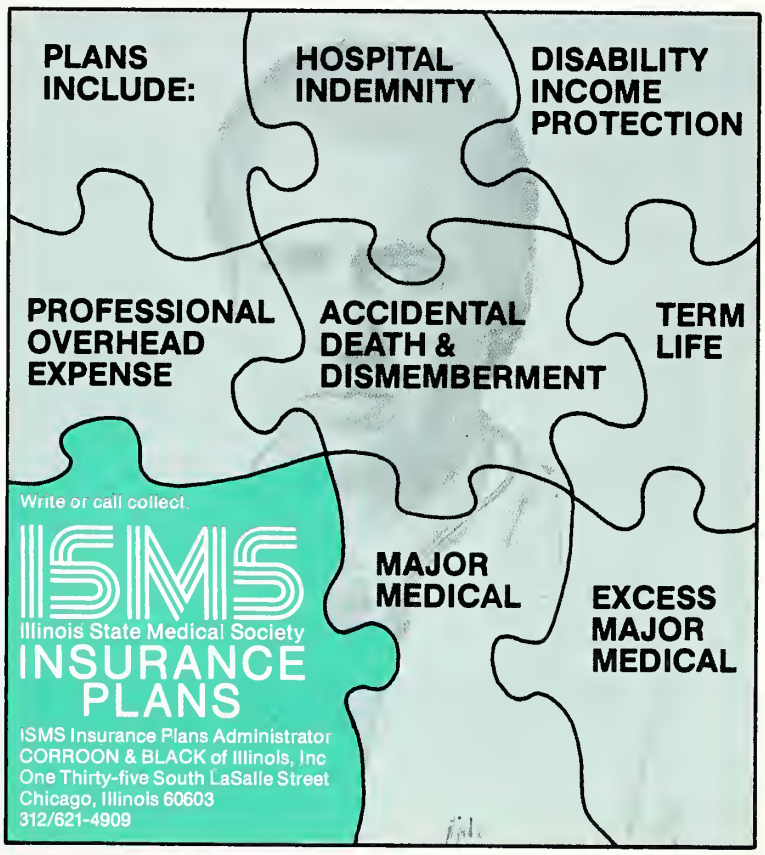


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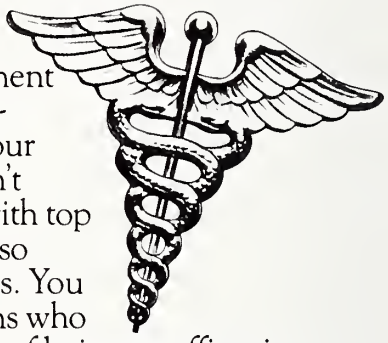
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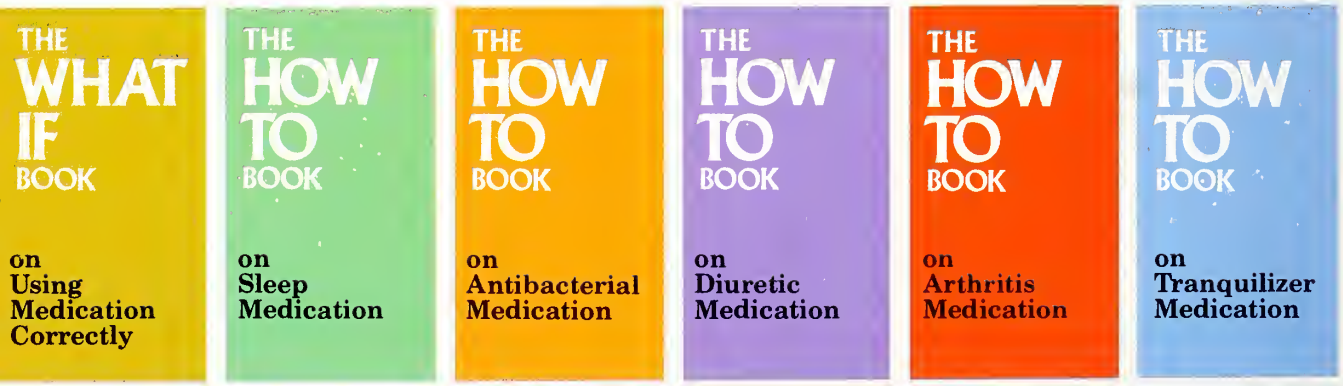
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Case Reports

Sarcoidosis Presenting With Massive Pleural Effusion

By R. Watts, Jr., M.D., J. Robert Thompson, M.D., F.A.C.P. and M. L. Jasuja, M.D., F.C.C.P./Chicago

A patient with sarcoidosis presented with massive right pleural effusion and other signs and symptoms suggesting pulmonary tuberculosis. Complete workup was negative for acid-fast infection. An excised cervical lymph node was typically non-caseating granuloma consistent with sarcoidosis. Steroid therapy was commenced with immediate physical improvement, weight gain and no recurrence of pleural effusion.

The nature of sarcoidosis is protean,[1] but very rarely presents with pleural effusion. While the diagnosis of sarcoidosis is not necessarily one of exclusion, certain features must be present: negative tuberculin reaction, abnormal immunoglobulins, hilar lymphadenopathy, negative myocobacteriology and recently, elevated angiotensin-converting enzyme values. We describe a patient who was admitted with massive pleural effusion and was suspected of having pulmonary tuberculosis.

Report of Case

A 22 year-old black man was admitted to our hospital in mid-1981. He had been seen in the health center in the morning complaining of cough with some blood-streaked sputum, weight loss of 12 kilograms and night sweats. He was afebrile. He gave a history of being in contact with an uncle who had active tuberculosis. The patient was a man of good habits.

Physical examination showed dullness and absence of breath sounds over the right chest and evidence of weight loss. No organomegaly was detected but palpable lymph nodes were present in the cervical area.

All blood parameters were within normal limits. Results of urinalysis, intradermal PPD, sputum and bronchial washing studies for acid-fast bacilli and cytology were negative. Alkaline phosphatase, LDH and SGOT values were all elevated significantly. Gamma globulin value was 2.3mg/dl, immunoglobulin A was 457mg/dl (normal range 86-370mg/dl) and immunoglobulin G was 1821mg/dl (normal range 666-1647mg/dl).

An X-ray film (Fig. 1) of the chest taken on the day of admission showed a massive pleural effusion on the right side with underlying infiltrates in the right lower lobe and hilar node enlargement. Four days after admission about 2500ml. of fluid was removed from the right pleural space. Analysis of this fluid revealed the following values: specific gravity 1.035, amylase 103 dye units/ml (normal range not known; normal range for blood serum 45-200 dye units/ml), glucose 94mg/dl, protein 494mg/dl and angiotensin-converting enzyme 56 units (normal range not known). The angiotensin-converting enzyme value for the blood serum was 40 units (normal range 12-36 units).

Enlarged cervical lymph nodes were removed for histologic study and showed non-caseating epithelioid granulomata. On inquiry, we learned that he had been seen in the health center six months before. In retrospect, the changes seen in the chest film (Fig. 2) taken at this time could well represent the picture of sarcoidosis.

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RISHER WATTS, JR., M.D., is o boord certified fomily proctitioner offilioted with Bethony Hospitol in Chicago. Dr. Wotts is o member of the ISMS Joint Proctice Committee ond olso the Chicogo Foundotion for Medicol Core.



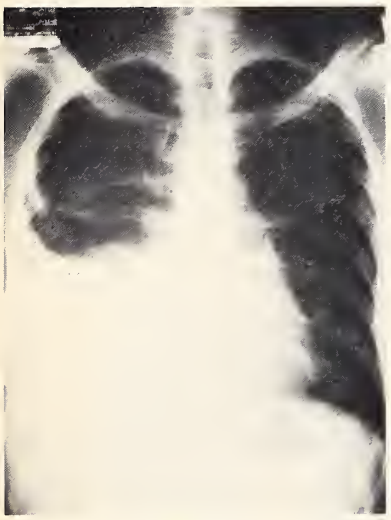


Figure 1
Right pleural effusion and bilateral hilar lymphadenopathy. There is a suggestion of pulmonary infiltrates.



Figure 2
This is a chest film taken five months before admission. Note the prominent hilar lymphadenopathy and pulmonary infiltrates.



Figure 3
Chest X-ray film three months later showing no significant hilar lymphadenopathy and no fluid in the right pleural space.

The patient was started on prednisone 40mg. daily a week after admission. Within 48 hours the patient was feeling better and at the time of discharge he had regained some of the lost weight. Follow-up visits to the health center showed continued weight gain and no evidence of disease progression or recurrence of pleural effusion. An X-ray film of the chest taken three months after admission (Fig. 3) showed no fluid in the pleural space, clearing of pulmonary infiltrates and marked reduction in prominence of hilar lymph nodes.

Discussion

The unusual finding of massive pleural effusion in sarcoidosis speaks in part for the protean nature of the disease. The most likely cause of the pleural effusion would be vascular and/or lymphatic obstruction.[2] It is speculated that after cortico-steroid therapy was begun, there was some reduction in the size of the lymph nodes relieving this obstruction. One cannot rule out the possibility that pleural involvement with sarcoid was responsible for the effusion, but this is considered to be less likely.

Only a few instances have been reported[3,4] of pleural effusion with sarcoidosis. Therefore, one is less likely to think of this disease in instances of pleural effusion and more likely to consider pulmonary tuberculosis or a malignant neoplasm.

It is difficult to weigh the value of a pleural fluid angiotensin-converting enzyme determination[5] (which in this case was higher than the blood serum level) since there are no reports of such determinations in effusions associated with sarcoidosis. The significance of an elevated serum angiotensin-converting enzyme has been well established in sarcoidosis, although it is not specific for this disease.

The pathologic features of sarcoidosis have been well documented but one of the most convincing findings is the presence of noncaseating granulomas in the perinodal fat outside the nodal structure itself (Fig. 4). These granulomata are almost always associated with blood vessels and may actually replace the blood vessel wall and project into the lumen.[6] ◀

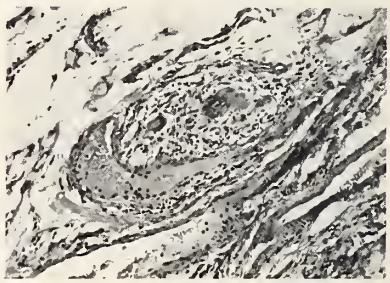


Figure 4
Photomicrograph of cervical lymph node. Note the noncaseating granuloma impinging on the wall of a large vessel. This is present in the perinodal fat (hematoxylin-eosin).

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FEBRUARY

Endocrinology

Outpatient Approach to Common Endocrine Disorders
For: FP's, GP's, Internists. Symposium, Feb. 19, 9:00 a.m., Urbana, IL. **Sponsor:** Carle Foundation Hospital, 611 W. Park, Urbana 61801. **Reg. deadline:** 2/17. **Fee:** $35. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Elective, 4 hours. **Contact:** Deborah Rugg. **Phone:** 217-337-3022.

Family Practice

Advances in Family Practice
For: GP's, FP's. Lecture, Feb. 14 (5 days), Chicago. **Speaker:** Harry Marchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $350. **Reg. limit:** 150. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Gastroenterology

Gastrointestinal Endoscopy
For: MD's. Lectures/workshops, Feb. 23-26, Milwaukee, WI. **Sponsor:** Section of Gastroenterology, Medical College of Wisconsin, P. O. Box 1608, Milwaukee, WI 53201. **Fee:** $350. **Reg. limit:** 250. **Credit:** Category 1, 25 hours; AAFP Elective, 25 hours. **Contact:** Walter Hogan, MD. **Phone:** 414/931-1030.

Medical Education

Simulated/Standardized Patients: Training & Use
For: MD's. Workshop, Feb. 21-23, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** yes. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Neurology

Basic Science of Neuralogy
For: Neurologists, Psychiatrists. Lecture, Feb. 21 (5 days), Chicago. **Speaker:** John Hughes, MD, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD, **Phone:** 312/733-2800.

Neurosurgery

Review Course in Neurological Surgery
For: Neurosurgeons, Neuralogists. Lecture, Feb. 4 (10 days), Chicago. **Speaker:** Leonard Kranzler, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Reg. limit:** 250. **Credit:** Category 1, 101 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathalagy

Liver and GI Clinico-Pathologic Conferences
For: MD's. Lecture, February 22, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** none. **Credit.** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Pediatrics

Pediatric Neurology: Review & Clinical Update
For: Pediatricians. Lecture, Feb. 28 (3 days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Speaker:** Lawrence Tomasi, MD, PhD. **Fee:** $275. **Reg. limit:** 90. **Credit:** Category 1, 24 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Specialty Review in General Surgery, Part II
For: General & Specializing Surgeons. Lecture, Feb. 21 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $600. **Reg. limit:** 300. **Credit:** Category 1, 100 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

MARCH

Arthritis

State of the Art
For: MD's. Lecture, March 16, 12:30 p.m., Hyatt House, Oak Brook. **Sponsor:** DuPage County Medical Society, 800 Roosevelt Rd., Bldg. 8, Rm. 300, Glen Ellyn 60137. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Lilliam Widmer. **Phone:** 312-858-9603.

Cardialagy

Coronary Disease: Evaluation & Treatment
For: MD's. Symposium, March 23, 6:00 p.m., Wood River. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Cardiology

Clinical Management of Coronary Disease
For: FP's, GP's, Internists. Seminar, March 25-27, McCormick Inn, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** $260. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800-525-8651 x 123.

Internal Medicine

Lake County Medical/Surgical Seminar
For: Internists, Surgeons. Seminar, March 23, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Speaker:** Gerald Bodey, MD. **Fee:** $5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Dr. Adelman. **Phone:** 312-578-2555.

Internal Medicine

State & National Board Review, Basic
For: MD's. Lecture, March 21 (6½ days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago. **Speaker:** Henry Jeffay, Ph.D. **Fee:** $450. **Reg. limit:** 90. **Credit:** Category 1, 62 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Internal Medicine

State & National Board Review, Clinical
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Medical Educotion

Evaluation of Clinical Competence
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Basic Mechanisms & Clinical Management of Shock
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Medicine

Dysfunctional Uterine Bleeding and Evaluation and Treatment of Infertility
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Medicine

Update on Arthritis
For: MD's. Symposium, March 10, 3:00-8:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Use and Abuse of Antibiotics
For: MD's. Symposium, March 31, 1:00-5:00 p.m., Floro. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Ophtholmology

Current Concepts Seminar
For: Ophthalmologists. Symposium/workshops, March 10-11, The Concourse Hotel, Madison, WI. **Fee:** T8A. **Reg. limit:** none. **Credit:** T8A. **Sponsor:** U of Wisconsin—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. : **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

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Laser Therapy of Glaucama
For: Ophtholmologists. Symposium/workshop, March 10-11, Chicaga. **Speaker:** Franz Fankhouser. **Sponsor:** Dept. of Ophtholmology, U af I College of Medicine, 912 S. Wood St., 2nd floor north, Chicago 60612. **Reg. deadline:** 2/24. **Fee:** $225, sympasium; $475, symposium & workshops. **Credit:** Category 1, 7 hours, symposium; 6 hours, warkshops. **Contact:** Sue Karienek. **Phone:** 312-996-8025.

Pathology

Liver & GI Clinico-Pathalagic Conference
For: MD's. Lecture, March 29, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivoiss, PhD. **Phone:** 312/578-3215.

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Rheumatology

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For: MD's. Symposium, Morch 31, 1:00 p.m., Pittsfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield. **Fee:** $45. **Reg. limit:** none. **Credit:** Cotegory 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217-782-7711.

Surgery

Fiberoptic Esophogogostric Endoscopy
For: Surgeons, Internists. Lecture, Morch 7 (2½ doys), Chicogo. **Speoker:** C. Thomos Bombeck, MD. **Sponsor:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 16. **Credit:** Category 1, 16 hours. **Contoct:** Robert Boker, MD. **Phone:** 312-733-2800.

Surgery

Honds Symposium
For: Surgeons, MD's. Symposium, Morch 25, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** none. **Reg. limit:** none. **Credit:** Cotegory 1. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

APRIL

Basic Science

Selection & Interpretotion of Laborotory Tests
For: Pothologists, primory core physicions. Conference, April 29-30, Modison, WI. **Sponsor:** U of WI—Extension, CME, 4658 WARF Bldg., 610 Wolnut St., Modison, WI 53705. **Fee:** T8A. **Reg. limit:** none. **Credit:** T8A. **Contact:** Soroh Aslokson. **Phone:** 608-263-2856.

Cardiology

Post Myocordiol Infarction Monogement
For: MD's. Symposium, April 8, 1:00 p.m., Taylorville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217-782-7711.

Cordiology

EKG Interpretotion ond Arrhythmio Management
For: GP's, FP's, Internists. Seminor, April 29-30, Hyott Regency, Chicogo. **Sponsor:** Internationol Medicol Educotion Corp., 64 Inverness Drive E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** $260. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; ACEP, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800-525-8651 x 123.

Gynecology

Current Monogement of Problems in Gynecology
For: Gynecologists. Course, April 22-23, Ritz Corlton Hotel, Chicogo. **Sponsor:** Dept. of O8/GYN, U of Chicogo, CME, 950 E. 59th St., Chicogo 60637. **Fee:** $195; $100, residents. **Credit:** Category 1, 9 hours; ACOG, 9 hours. **Contoct:** Mory Ann Dillon. **Phone:** 312-962-1056.

Infectious Diseose

Advances in Infectious Diseose
For: MD's. Conference, April 14-16, Modison, WI. **Sponsor:** U of WI—Extension, CME, 465b WARF Bldg., 610 Wolnut St., Modison, WI 53705. **Fee:** T8A. **Reg. limit:** none. **Credit:** Cotegory 1, AOA. **Contoct:** Soroh Aslokson. **Phone:** 608-263-2856.

Industriol Injuries

Case Resolution of Complex Industriol Injuries
For: MD's. Conference, April 28-29, Appleton, WI. **Sponsor:** U of WI—Extension, CME, 465b WARF Bldg., 610 Wolnut St., Modison, WI 53705. **Fee:** T8A. **Reg. limit:** none. **Credit:** Cotegory 1. **Contoct:** Soroh Aslokson. **Phone:** 608-283-2856.

Medicine

Gostrointestinol Problems
For: MD's. Symposium, April 19, 7:00 p.m., Vondolio. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Cotegory 1, 3 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217-782-7711.

Neurorodiology

Neurorodiology Review Course
For: Generol Rodiologists, Neurorodiologists, Neurosurgeons. Course, April 30-Moy 1, Morriott Hotel, Oak Brook. **Sponsor:** Loyolo University Center CME, 2160 S. First Ave., Moywood 60153. **Fee:** $140; $80, residents. **Credit:** Cotegory 1, 15 hours. **Contoct:** Lindo Gunzburger, PhD. **Phone:** 312-531-3237.

OB/GYN

Immunology of Reproduction
For: MD's. Lecture, April 22, 8:00 o.m., Chicogo. **Sponsor:** UHS/CMS. **Cosponsor:** Cook County Hospitol, 1825 W. Horrison St., Division of Gynecologic Oncology, Chicogo 60612. **Reg. deodline:** 2/15. **Reg. limit:** none. **Credit:** Cotegory 1, 8 hours. **Contact:** Ben Blivoiss, PhD. **Phone:** 312-578-3215.

Office Monogement

Office Management ond Computers
For: MD's. Symposium, April 7, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Cotegory 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217-782-7711.

Pothology

Liver and GI Clinico-Pothologic Conference
For: MD's. Lecture, April 26, 4:30 p.m., North Chicogo. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Boy Rood, North Chicogo 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben 8livoiss, PhD. **Phone:** 312-578-3215.

Pothology

Speciolty Review in Pathology/Anotomic
For: Pathologists. Lecture, April 11 (6 days), Chicogo. **Speoker:** Alvin Ring, MD. **Sponsor:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $425. **Reg. limit:** 90. **Credit:** Category 1, 48 hours. **Contoct:** Robert Boker, MD. **Phone:** 312-733-2800.

Pothology

Specialty Review in Pathology, Clinical
For: Pathologists. Lecture, April 18 (5 days), Chicogo. **Speoker:** Alvin Ring, MD. **Sponsor:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 90. **Credit:** Category 1, 41 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Pothology

Hematopathology, Leukemios & Leukemoid Reactions
For: Pathologists. Lecture, April 11, 7:30 p.m., Droke Hotel, Chicogo. **Speoker:** J. Vordimon, MD. **Sponsor:** Chicogo Pothology Society, c/o Morsholl Short, MD, Loretto Hospitol, 645 S. Centrol Ave., Chicogo 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Cotegory 1, 2 hours. **Phone:** 312-626-4300 x 383.

Pulmonary Diseoses

Pulmonory Diseoses Symposium
For: MD's. Symposium, April 28, 1:00 p.m., Jocksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217-782-7711.

Radiology

Rodiology Updote
For: MD's. Symposium, April 13, 6:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Cotegory 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217-782-7711.

Rodiology

Speciolty Review in Rodiology
For: Rodiologists. Lecture, April 25 (5 days), Chicogo. **Speoker:** Rogelio Moncodo, MD. **Sponsor:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert 8oker, MD. **Phone:** 312-733-2800.

Rheumotology

Rheumatology
For: MD's. Symposium, April 30, 1:00 p.m., Mt. Cormel. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217-782-7711.

Surgery

Fiberoptic Colonoscopy
For: Surgeons. Lecture, April 27 (2½ doys), Chicogo. **Speoker:** Herond Abcorion, MD. **Sponsor:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 20. **Credit:** Cotegory 1, 15 hours. **Contact:** Robert 8oker, MD. **Phone:** 312-733-2800.

Surgery

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons. Lecture, April 23, Chicogo. **Speaker:** Herond Abcorion, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $125. **Reg. limit:** 60. **Credit:** Cotegory 1, 7 hours. **Contoct:** Robert 8oker, MD. **Phone:** 312-733-2800.

Urology

Speciolty Review in Urology
For: Urologists. Lecture, April 25, (5½ days), Chicogo. **Speaker:** Thomos John, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Reg. limit:** 200. **Credit:** Category 1, 53 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Utilizotion Review

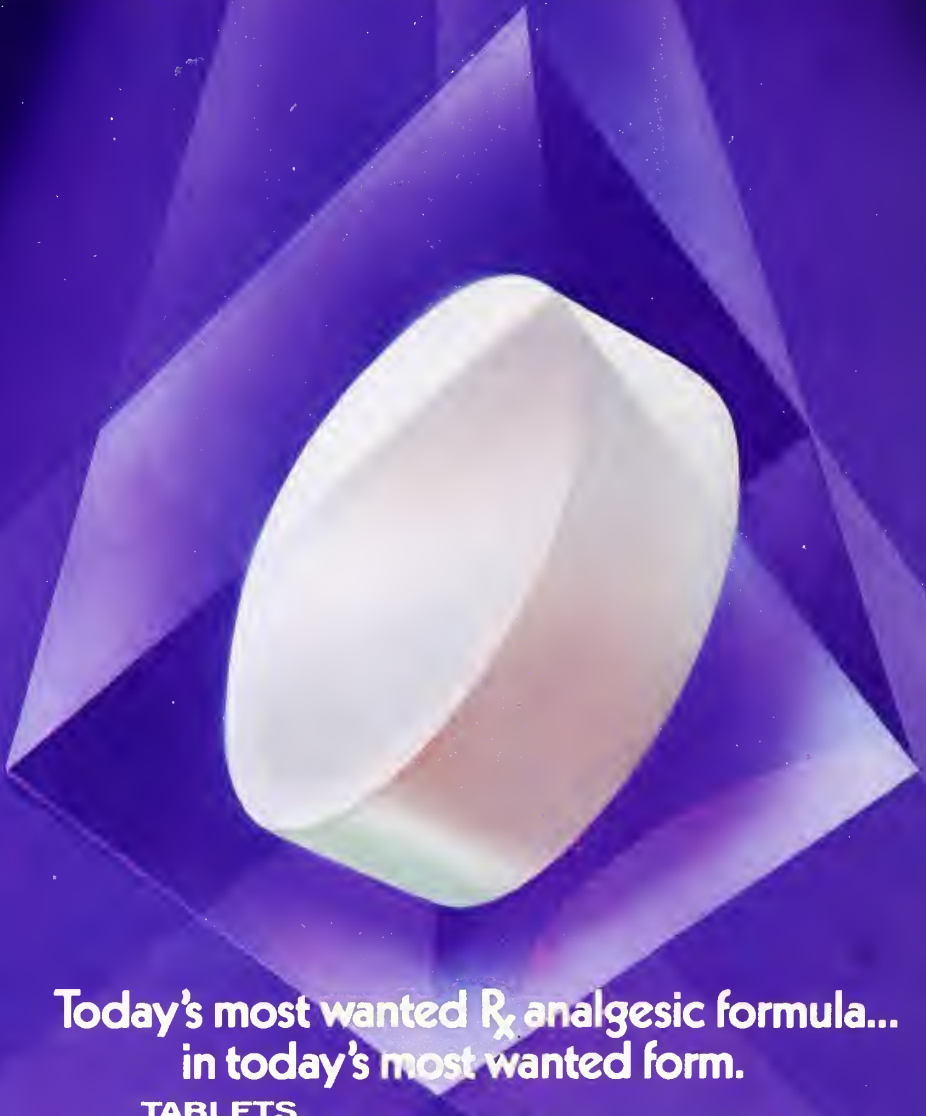
Third Porty Poyers
For: MD's. Lecture, April 17, Morriott Hotel, Oak Brook. **Sponsor:** Illinois Regionol Chopter of Americon College of Utilization Review Physicions, c/o 1108 N. Second Street, Horrisburg, PA 17102. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Cotegory 1, 5 hours. **Contact:** Betty Hommon. **Phone:** 717-697-4428.

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The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.
The concurrent use of anticholinergics with codeine may produce paralytic ileus.
Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.
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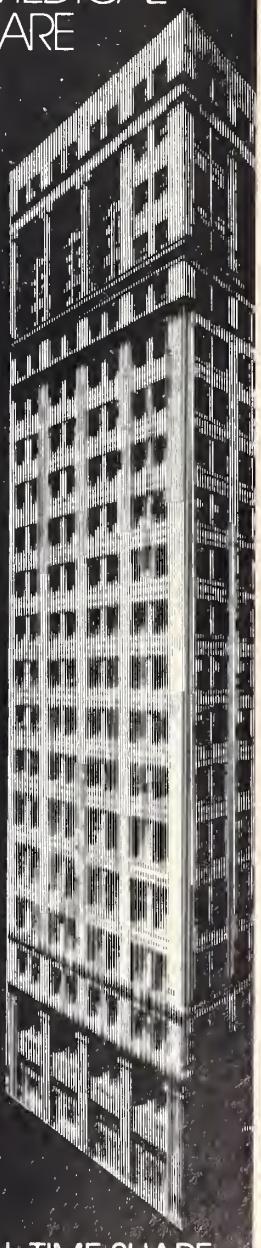
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Viewbox

(Continued from page 12)

Answer: (3)

The possible harm associated with radiation received during diagnostic radiology procedures is of increasing concern to patients. The danger of diagnostic X-ray exposure has frequently been featured in the mass media and patients are now asking physicians more questions about radiation. All physicians should be aware of these issues and be prepared for questions from their patients. Material provided in the following discussion is intended as an introduction to this subject.

Terms

It is appropriate to first define those terms used in describing and measuring radiation. The unit *Roentgen* measures the amount of radiation that a region is exposed to and is called the *unit of radiation exposure.* The amount of radiation energy absorbed per gram of tissue is expressed in *rads,* the *unit of absorbed dose.* The *rem* (Roentgen equivalent man) unit specifies *biologically significant harm* imparted by radiation; some types of radiation (*e.g.,* neutron beams) are more damaging than others (*e.g.,* X-rays).

It is helpful that a 1 Roentgen (R) exposure of diagnostic X-rays results in about 1 rad absorbed dose in soft tissue and a 1 rem biological dose. For this reason these terms are often used interchangeably, although they express different concepts.

For purposes of discussing radiation risk, it is usually appropriate to specify the average dose throughout critical organs receiving radiation. For example, the dose where the X-ray beam enters the skin during a xeromammogram might typically be 1 rem, the dose at the center of the breast 0.4 rem and the average dose throughout the breast 0.5 rem.

Finally, it should be kept in mind that radiation risk is proportional to the area of the body over which a given dose is received. A patient who had only one breast X-rayed would incur half the risk of one who had both X-rayed, assuming similar radiographic techniques were employed in each case. However, both of these patients might legitimately be told they received "0.5 rem." Similarly, an individual who has received 1 rem whole-body has absorbed much more radiation energy and is given greater risk than a patient whose hand alone received 1 rem during a series of radiographs.

Radiation Dose—Radiologic Procedures

It is impossible to specify the exact radiation dose patients will receive from each procedure, as this will vary with patient size, the type of equipment in use, the technique factors employed, etc. For upper and lower GI exams, cumulative fluoroscopy time and number of spot films will greatly influence total patient dose. Keeping these modifiers in mind, Table 1 contains some patient dose values we feel are representative based on experience at our institution and other institutions we are familiar with. The dose could easily vary by a factor of two or more from patient to patient and between institutions.

As might be expected, doses range from tenths of a rem to several rem, depending on the type of exam. If, by proper collimation, the direct X-ray beam is restricted to areas away from the pelvis, as would normally be the case for films of the chest, skull and extremities, fetal dose is due largely to a small radiation scatter component and is generally less than the fetus would receive from natural background sources of radiation during the course of a normal length pregnancy.

Risk

The effect of low-level radiation on the body, *i.e.,* the few rems or less normally received as a result of diagnostic X-rays, continues to be an active area of scientific inquiry.[1] These studies are difficult because low-level radiation effects occur with such small probability that they are easily masked by normal variations in occurrence of such effects between population groups. All of the maladies radiation is thought to produce also occur "naturally" in groups of people who have not been irradiated.

It now seems that cancer induction is the hazard of most concern in the low radiation dose range. Fetal malformation (*e.g.,* microcephaly) may be produced by radiation doses on the order of 15-20 rem, but is not generally held to be of a prime concern at levels below 10 rem.[2] Available evidence suggests that the rate of genetic mutation in groups of individuals exposed to diagnostic levels of radiation would be virtually indistinguishable from the natural rate in unirradiated groups.

For the reasons mentioned above, there are no cases of cancer proven to have been caused by 1 rem of radiation. However, there is evidence that cancer radiogenesis is a stochastic, non-threshold process, meaning even small doses have admittedly small but non-zero fatal potential.[3] The task thus becomes one of quantifying, or at least estimating, this potential risk.

Low level radiation risk estimates are generally obtained by extrapolation of data on the number of fatalities caused by high radiation doses. The manner in which this is done is a matter of some

TABLE 1.

Typical radiation doses (rem) for average size adult patients undergoing common radiologic procedures.

PROCEDURE	SKIN (ENTRANCE) DOSE	FETAL DOSE
PA Chest Film (1)	0.02	<.002
AP Skull Film (1)	0.39	<.005
AP Abdomen Film	0.43	0.15
Upper GI Exam	5.5	0.2
Lower GI Exam (Air Contrast)	9.0	3.0
Xeromammogram (1 Image)	1.2	<0.01
CT Skull	2.0	<0.03
CT Pelvis	2.4	1.2
Annual Background Level	0.1	0.06
Round Trip Transcontinental Flight	0.01	0.01

debate; different shapes of the effect-versus-dose curve are advocated. Additional risk estimates have been obtained from retrospective epidemiological studies, such as those of Stewart,[4] which demonstrate a definite correlation between prenatal exposure and subsequent childhood cancers in those irradiated in-utero.

The bulk of statistical data indicates that if a population of one million adults is given one rem *whole-body dose,* an extra 100 cancer fatalities will be produced.[1] If the normal adult cancer fatality rate is taken as 100,000 per million, the 1 rem whole-body dose subjects the adult to an increased risk of 0.1%.

One must be careful in using these risk factors to estimate the hazard to those patients exposed to X-rays. In contrast to whole-body radiation, diagnostic X-rays result in irradiation of only a fraction of the body tissue. Furthermore, average dose for organs in the beam is considerably less than the commonly quoted skin or entrance dose. Gregg[5] has described a method for estimating risk in such cases. Using this approach, if the abdominal film contemplated in our case example involved a skin dose of *0.4 rem* to the woman, the equivalent whole-body dose for equal risk to her would be about *0.02 rem.*

It is difficult for most of us to relate to risk when it is expressed as percentage probability or number of cases per million. Cohen[6] has compared the risk associated with various common activities, including radiation exposure, in terms of average number of days of life lost due to these activities. If we apply Cohen's technique to our abdominal film, we conclude that the risk of the film is equal to that the woman would subject herself to by driving seventy miles or smoking three cigarettes. Each of these activities would, statistically, result in an average loss of 30 minutes of life.

Although fraught with contradictions, the data pertaining to prenatal radiation risk tends to make one more uneasy. In retrospective studies of large numbers of pregnant women who required studies which placed the fetus in the direct X-ray beam, Stewart's[4] results indicate we can expect an extra 400 childhood cancers per million fetuses receiving about 1 rem. This is to be compared to a normal childhood cancer rate of about 1000 per million.

Questions naturally arise as to whether the childhood malignancies in question might be correlated with but not actually produced by the X-rays. Could it be true, for example, that the population group selected in the Stewart study was, for some undetermined reason, more prone to malignancy? The issue is further complicated by the fact that Jablon and Kato[7] reported no similar increase in malignancy when children of atomic bomb survivors, who were irradiated *in-utero,* were followed. The population group studied by them was small compared to that of Stewart.

If, as many people expect, the Stewart data is eventually proven to demonstrate a causal link between radiation and future malignancy, we would conclude that the taking of about five abdominal radiographs subjects a fetus to a childhood cancer risk increase of 40%. This would mean about one additional cancer per 2000 fetuses receiving 1 rem. There would be one additional cancer per 200 individuals at a 10 rem dose level (which would practically never be produced as the result of diagnostic procedures). The absolute risk any one fetus encounters from a few films is, thus, less disturbing than risk expressed on a percent basis. Nonetheless, special caution is always indicated when ordering radiologic studies on pregnant or potentially pregnant women.

Recommendations

As with other diagnostic procedures, the physician ordering radiologic examinations must have reasonable confidence that benefit to the patient will outweigh the risk of the study. Implicit in this dictum is the requirement that physicians ordering radiographs formulate clearly in their own minds the type of information being sought. In so doing the referring physician will help insure that only needed X-rays are taken and will be doing his part in keeping radiation doses as low as reasonably achievable.

Although cumulative radiation dose limits are legally applied to radiation workers, it is doubtful that there is any "threshold" dose or cumulative body burden of radiation beyond which it suddenly becomes unsafe to take another X-ray. It would seem more reasonable, and practical, to consider each prospective X-ray procedure individually in terms of its own benefits weighted against the increment of cancer risk it will present to the patient.

Because of the relatively greater fetal radiation risk, extra caution is called for when pregnancy is suspected. Both the U.S. Council on Radiation Protection and Measurements (NCRP)[2] and the Bureau of Radiological Health[7] recommend that *referring physicians,* prior to ordering radiologic studies of the pelvis or lower abdomen, determine by direct questioning if female patients of childbearing age are or could be pregnant. In such cases, if it is determined that the woman may be pregnant, and if the procedure is considered elective, it is recommended that the procedure be postponed in accordance with the "10-day rule" (given as Choice 1). The exam is considered elective if, in the words of NCRP, it "does not contribute to diagnosis or treatment in relation to an immediate illness." This is clearly a matter of physician judgment. It is worth noting that many radiology departments have initiated their own pregnancy screening procedures. In our department almost all women of childbearing age are asked if they might be pregnant, and signs concerning this are posted on dressing room doors (Fig. 1). These screening procedures are intended to supplement, but not replace, the efforts of the referring physician.

If it is decided that the studies of a pregnant woman are necessary, the exam should be carried out with dispatch. In this event, the referring physician should alert radiology personnel to the potential pregnancy so that steps can be taken to limit radiation exposure of the lower abdomen, consistent with obtaining the needed information.

Radiology of body regions other than the lower abdomen or pelvis can proceed as normal. If the technologist properly collimates the X-ray beam, films of extremities, the skull or even the chest should result in low fetal dose. However, it is still advisable in this case to notify Radiology when a pregnancy is suspected so that additional shielding of the lower abdomen can be employed during the exam, as a fail-safe precaution. This would serve to alleviate the patient's fear as well as further reduce radiation to the fetus or embryo.

References

1. Sinclair, W.K.: "Effects of Low-Level Radiation and Comparative Risk," *Radiology* 138:1-9, 1981.
2. NCRP Report No. 54: "Medical Exposure of Pregnant and Potentially Pregnant Women."
3. Upton, A.C.: "The Biological Effects of Low-Level Ionizing Radiation," *Scientific American* 246 #2:41-49, 1982.
4. Stewart, A.: "The Carcinogenic Effects of Low-Level Radiation," *Health Phys.* 24:223, 1973.
5. Gregg, E.C.: "Radiation Risks with Diagnostic X-Rays," *Radiology* 123:447-453, 1977.
6. Cohen, B.L. and Lee, I.: "A Catalog of Risks," *Health Phys.* 36, 707-722, 1979.
7. U.S. Dept. of Health and Human Services, Bureau of Radiological Health, HHS Publication FDA 81-8178, "Procedures to Minimize Diagnostic X-Ray Exposure of the Human Embryo and Fetus."
8. Jablon, S. and Kato, H.: "Childhood Cancer in Relation to Prenatal Exposure to Atomic Bomb Radiation," *Lancet* 2, 1000, 1970.



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Obituaries

**Carelli, Paul V., II, Oak Park, died November 28, 1982 at the age of 77. Dr. Carelli was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

*Hamilton, Samuel Logan, Palos Heights, died December 1, 1982, at the age of 69. Dr. Hamilton was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

**Hauser, Emil D. W., Sun City, Arizona, died November 18, 1982 at the age of 85. Dr. Hauser was a 1922 graduate of the University of Minnesota Medical School, Minneapolis.

**Kearns, Jerry, Chicago, died December 8, 1982 at the age of 90. Dr. Kearns was a 1927 graduate of the University of Illinois College of Medicine, Chicago.

*Napolilli, Francis A, Park Ridge, died November 10, 1982 at the age of 76. Dr. Napolilli was a 1937 graduate of the Loyola University Stritch School of Medicine, Maywood.

**Nelson, Peter A., Fort Lauderdale, Florida, died October 21, 1982 at the age of 82. Dr. Nelson was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

*Rothenberg, Harold J., Chicago, died October 30, 1982 at the age of 68. Dr. Rothenberg was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

*Streicher, Daniel Leo, Lincolnwood, died November 20, 1982 at the age of 63. Dr. Streicher was a 1943 graduate of the University of Illinois College of Medicine.

*Waner, W. L., Chicago, died November 23, 1982 at the age of 83. Dr. Waner was a 1926 graduate of Rush Medical College, Chicago.

*Youngberg, Paul, Rock Island, died November 30, 1982 at the age of 87. Dr. Youngberg was a 1924 graduate of Tufts University School of Medicine, Boston.

Indicates ISMS member
***Indicates member of the Fifty Year Club*

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

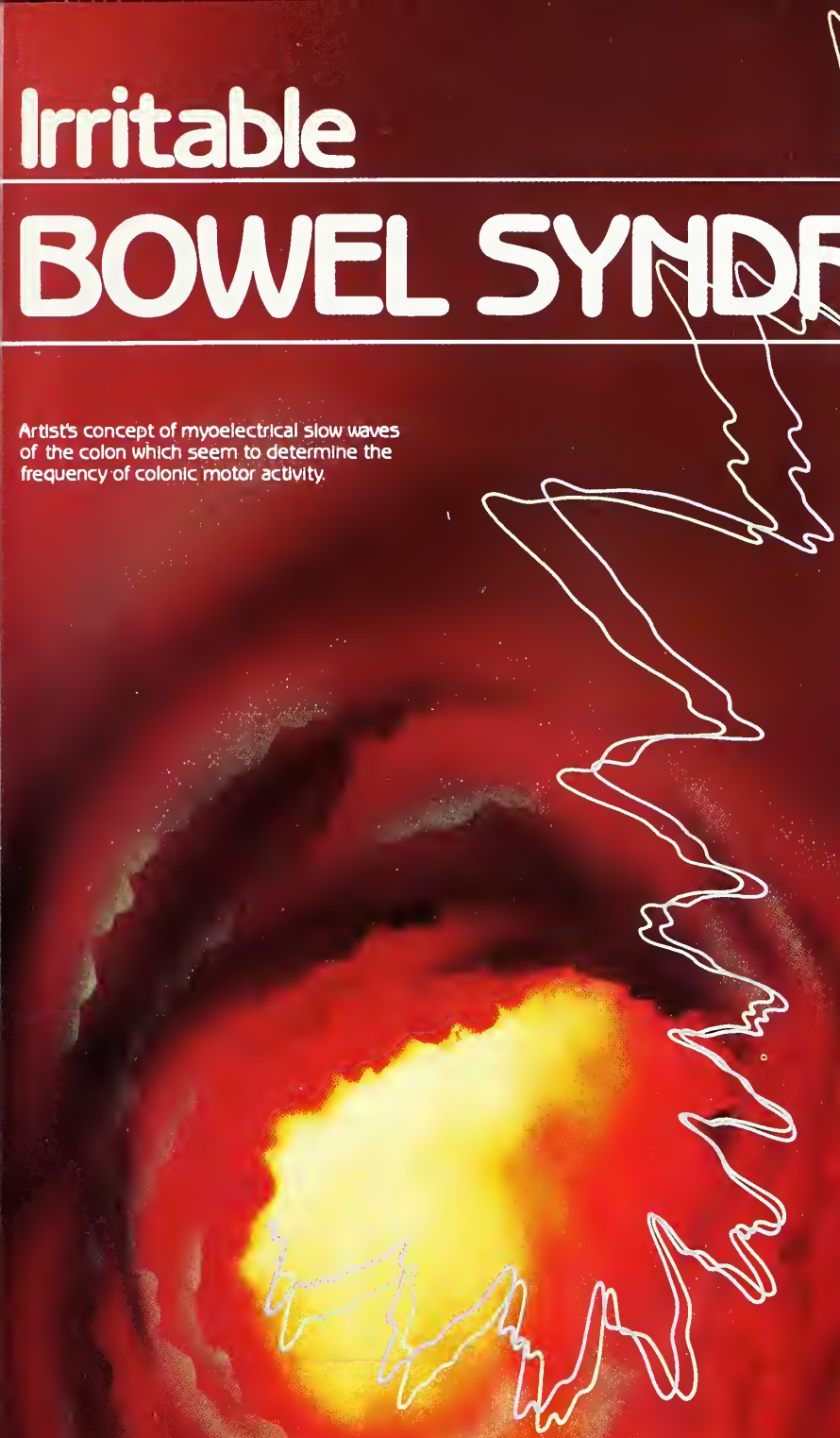
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Irritable BOWEL SYNDROME*



Artist's concept of myoelectrical slow waves of the colon which seem to determine the frequency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

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Librax: A logical choice for patients with IBS

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References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med* 298:878-883, Apr 20, 1978. **2.** Snape WJ *et al*: *Gastroenterology* 72: 383-387, Mar 1977.

Specify Adjunctive **Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

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*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

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President's Page



Hospital Medical Staff Organization

Traditionally, hospital medical staff bylaws have confined membership to doctors of medicine or osteopathy and doctors of dental surgery. Recent years have seen the proliferation of health care providers with restricted licenses, such as podiatrists, clinical psychologists, midwives, nurse practitioners and others. The extent to which these individuals may practice some aspect of medicine varies from state to state. Physicians are very concerned that the high standards of patient care continue to be maintained. However, as an organized group, they may not restrict the legitimate activities of other health care providers without risking infringement of anti-trust laws. In Illinois, we physicians have been subject to such an anti-trust action brought against the Illinois State Medical Society by five chiropractors. Though the circuit court findings were in favor of the physicians, this case is still under appeal and has not been finally resolved.

Recently, the AMA House of Delegates addressed this delicate problem and gave specific instructions to its representatives on the Joint Commission on Accreditation of Hospitals' Board of Commissioners. The representatives were instructed to insist that any new recommendations affecting the organization of health care providers within a hospital setting retain appropriate physician influence to guarantee the quality of patient care within the hospital. Only physicians are trained in the all inclusive prevention, diagnosis and treatment of human ailments. It stands to reason that physicians must play the major role in defining the parameters of quality in health care.

C. C. Wiggishoff M.D.

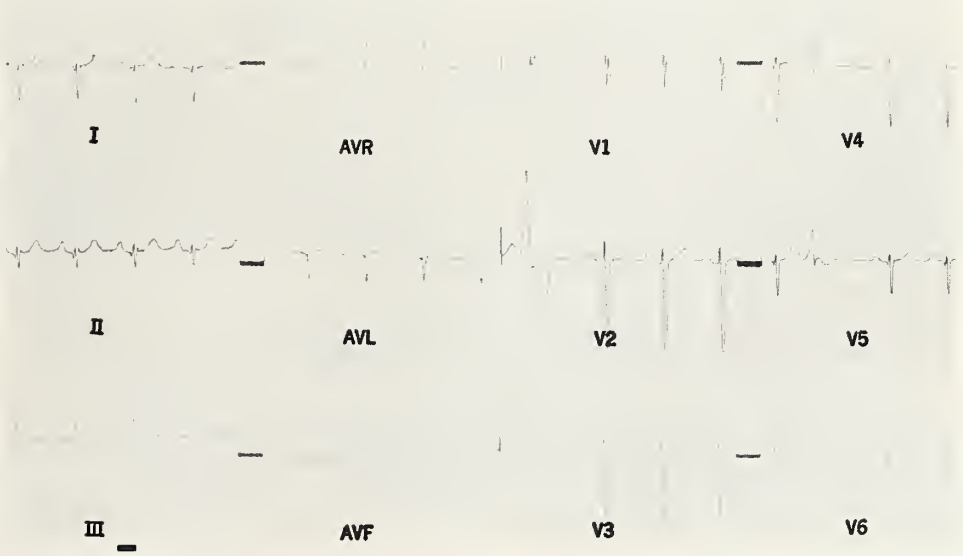
Cyril C. Wiggishoff, M.D., President



EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., Dovid J. Hole, M.D., Potrick J. Sconlon, M.D., Soroh A. Johnson, M.D., John R. Tobin, M.S., M.D., ond Rolf M. Gunnor, M.S., M.D., Section of Cordiology, Deportment of Medicine, Loyolo University Stritch School of Medicine

This patient is a sixty-two year old woman who came to the emergency service because of weakness, fatigue, and some respiratory distress. She had a history of a heart murmur since age six years, but had never consented to a cardiac catheterization. Her temperature was 102°F. Examination of the lungs showed left base dullness and medium crepitant rales. The heart murmur was a grade 3/6 systolic murmur loudest at the left sternal border and the base. The first heart sound was normal and the second sound was widely, but normally, split. P_2 was diminished. The white blood cell count was 11,800 with a left shift. Arterial blood gases showed oxygen desaturation. A chest X-ray showed a large left lower lobe infiltrate. There was cardiomegaly with a large pulmonary artery segment. Pulmonary vascularity was diminished. A gram strain of the sputum revealed gram positive diplococci. A twelve lead ECG was obtained and is shown.



Questions:

1. **The twelve lead ECG shows:**
   a. Right ventricular hypertrophy.
   b. Right axis deviation.
   c. Right atrial enlargement.
   d. Right bundle branch block.
   e. Left ventricular hypertrophy.

2. **Based on the information given, the most likely cardiac diagnosis is:**
   a. Ventricular septal defect.
   b. Atrial septal defect.
   c. Tetralogy of Fallot.
   d. Pulmonic stenosis.
   e. Mitral regurgitation.

(Continued on page 134)

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Suite 590, 999 Plaza Drive, Schaumburg, Illinois 60195
(312) 843-7214

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W. J. NATTERMANN
Suite 580, One North Old Capitol Plaza, Springfield 62705
(217) 544-2251

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Resumé

Objective:

To improve cash flow and efficiency of medical offices.

Experience,
1967 to present:

Presently work for more than 450 medical offices in 30 states. Perform a wide variety of computerized functions:

Billing Clerk. Routinely issue bills on time. Cut accounts-receivable turnaround. Reduce "lost" charges.

Collection Agent. Automatically generate past-due notices. Include personalized messages such as reminders of promises to pay.

Efficiency Expert. Recommend the best systems and procedures. Free administrators from month-end commotion of typing, stuffing, and mailing patient statements. Furnish attending physicians with daily schedules, case histories, chart room pull lists, route slips, and more. Issue patient recalls automatically.

Insurance Forms Processor. Provide computer-prepared insurance forms every week. Automatically mail to patient when requested.

Financial Advisor. Give up-to-the-minute reports on accounts of individual patients and overall profit/loss picture.

Trainer. Train clinic staff when system goes into operation. Train new employees. Always available for questions and consultations.

References:

Gladly furnished upon request.



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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

February 7	Hinsdale Sanitarium & Hospital & A.C.S.	Hinsdale
February 8	Northwestern Memorial Hosp. & Chicago Lung Assn.	Chicago
February 16	St. Mary Hospital	Quincy
February 17	ACS Training	Chicago
February 28	Condell Memorial Hosp. & A.C.S.	Libertyville
March 1	Illinois Interagency Council on Smoking & Disease/Chgo. Dept. of Health	Chicago
March 1	John Hersey H.S. & Chgo. Lung Assn.	Arlington Hts.
March 7	Lake Forest Hosp. & A.C.S.	Lake Forest
March 8	Northwestern Memorial Hosp. & A.C.S.	Chicago
March 17	ACS Training	Chicago
March 21	Luthern Gen. Hosp. & Chgo. Lung Assn.	Park Ridge
April 4	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
April 5	Illinois Interagency Council on Smoking & Disease/Chgo. Dept. of Health	Chicago
April 5	Northwestern Memorial Hosp. & A.C.S.	Chicago
April 15	A.C.S. Training	Chicago
May 2	St. Therese Area Satellite & A.C.S.	Lake Villa
May 3	Northwestern Memorial Hosp. & A.C.S.	Chicago
May 2	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
May 3	Illinois Interagency Council on Smoking & Disease/Chgo. Dept. of Health	Chicago
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Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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Antianxiety/Antisecretory/Antispasmodic

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*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

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- ☐ Physician policyholders own the insurance company
- ☐ All profits returned to policyholders
- ☐ Program and policies established by physician owners
- ☐ Physician committees review all underwriting actions
- ☐ Active loss prevention education effort

YOUR CLAIMS

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- ☐ Your participation in settle/defend decisions

YOUR COVERAGE

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Obituaries

***Berman, Julian L.,** North Chicago, died December 4, 1982 at the age of 47. Dr. Berman was a 1960 graduate of the Hahnemann Medical College and Hospital, Chicago.

***English, Harlan,** Danville, died January 2, 1983, at the age of 74. Dr. English served as ISMS president in 1963-64 and had been an ISMS member for 48 years.

Dr. English was an AMA Delegate for 25 years and served on the AMA Council on Legislation as well as the AMA Council on Medical Education and Hospitals. A urologist, he was a fellow of the American College of Physicians.

Dr. English was a 1934 graduate of the University of Illinois College of Medicine. He helped to organize and administer the Illinois Medical Student Loan Fund Program which is jointly sponsored by the Illinois Agricultural Association and ISMS.

Dr. English is survived by his wife, Margaret Steele English, a sister, a niece and two nephews.

***Hong, C. K. Michael,** Dixon, died November 27, 1982 at the age of 47. Dr. Hong was a 1958 graduate of the College of Medicine Seoul National University, Seoul.

***Hursh, M. Douglas,** Putnam, died November 15, 1982 at the age of 70. Dr. Douglas was a 1938 graduate of the University of Minnesota Medical School, Minneapolis.

****Kirschbaum, Walter R.,** Chicago, died August 15, 1982 at the age of 88. Dr. Kirschbaum was a 1919 graduate of the Freidrich-Wilheims Universtat Medizinische Fakultat, Berlin.

***Massel, Hyman,** Chicago, died December 19, 1982 at the age of 79. Dr. Massel was a 1927 graudate of the University of Illinois College of Medicine.

***Norman, Max,** Chicago, died December 7, 1982 at the age of 72. Dr. Norman was a 1934 graduate of Medizinische Fakultat der Universitat Heidelberg, Baden-Wurttemberg.

***Walsh, James J.,** River Forest, died December 13, 1982 at the age of 74. Dr. Walsh was a 1933 graduate of the Loyola University Stritch School of Medicine.

**Indicates ISMS member*
***Indicates member of the Fifty Year Club*



Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Population 7,000, County—17,000. Hospital looking to recruit three physicians for primary care solo and/or group practice. Twenty-Five miles from Carbondale and the SIU-Medical School. Financial assistance negotiable. Hospital office suites available soon for physicians' practice. Contact: Ken Simpson, 517 N. Main, Anna 62906 618-833-5155. (5)

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GENEVA: SMALL TOWN MEDICINE/BIG CITY ADVANTAGES—Seeking physician to join board certified active family practice group. Thriving community of 10,000, west of Chicago. Modern, well equipped, 3 physician office with full lab and x-ray facilities. 110 bed primary care hospital 1 mile from office. Salary guarantee, malpratice coverage, other benefits. Opportunity for full partnership. Send resume and C.V. to: P.O. Box 72, Geneva, Illinois 60134. (3)

GLEN ELLYN: Physicians wanted to staff urgent care and industrial medicine facility in private practice in western suburbs of Chicago. Hourly base plus incentive package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, S. C., 454 Pennsylvania Ave., Glen Ellyn 60137. 312-469-9200. (5)

GLEN ELLYN: Physicians wanted—internist and family physician to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. CONTACT: Dave Bauer, Adm., Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave., Glen Ellyn 60137 (312-469-9200). (5)

GRIGGSVILLE: North Pike County in immediate need of family practitioner. Practice partnership opportunity with established FP. Remodeled clinic, six months' free rent with supplies and basic equipment. 78-bed hospital with OB and C/CCU, pathologist and radiologist on site. Service area of 19,000 with 3 surgeons and 7 GPs (5 FAAFP). Medical student preceptorships on site and within one hour of family practice residency. One hour from Quincy, 1½ hours from Springfield, 2 hours from St. Louis. Excellent recreational facilities nearby. Contact Ronald Johnson, MD, FAAFP, 121 N. Franklin, Pittsfield 62363 (217-734-2386) or Cheryl Bielema, 110 N. Union, Griggsville 62340 (217-833-2665). (3)

LA HARPE:—Population 1200. Seeking replacement for one of two Family Physicians in community. 64 bed hospital including 49 long term; affiliation with nearby regional medical center; office facilities and financial assistance available. Educational/recreational facilities—Mississippi River nearby. Contact: Richard Miller, Administrator, La Harpe Hospital, La Harpe 61450, 217/659-3011. (3)

ROSICLARE: FAMILY PRACTITIONER/INTERNAL MEDICINE—53-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare 62982. (618) 285-6634. (3)

SAYBROOK: Family practitioner—Excellent opportunity in East Central Illinois; large modern office available due to recent physician retirement; rural setting near modern well equipped community hospital; also within twenty minutes of major university tertiary care center, metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact: William Stack, Saybrook 61770. (309) 475-3521. (5)








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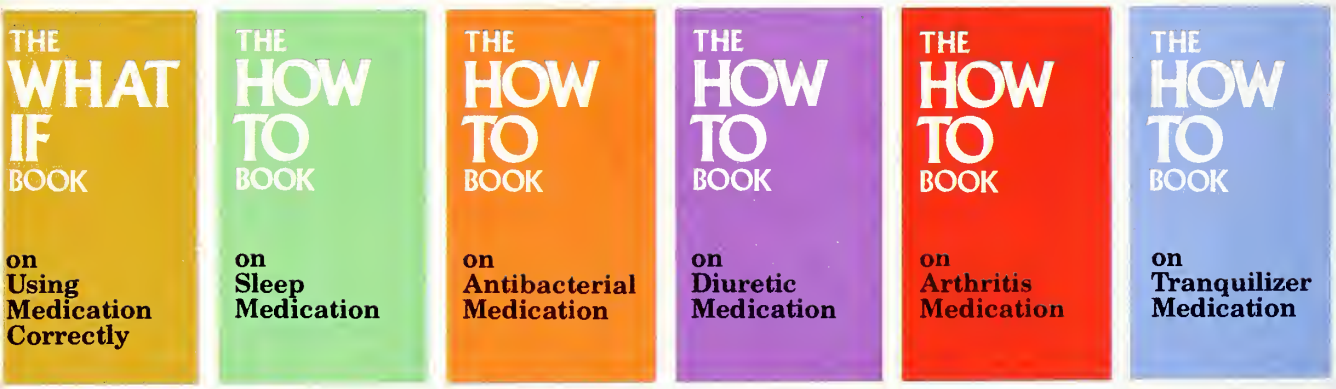
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Illinois Society, American Association of Medical Assistants

Certification of the Medical Assistant

By Robin L. Bluestein, CMA-C

Illinois Society, the American Association of Medical Assistants, is dedicated to the professional advancement of medical assistants through medical education and through certification. We seek to maintain a standard of excellence within the profession of medical assisting through continuing medical education programs and urge our members to take the national certification examination.

Those working and active within the organization wanted a way of determining competence within the field of medical assisting. The first certification examination was developed and offered in 1963.

The certification examination tests the medical assistant's general knowledge of the skills used in day-to-day office functioning, including both clinical and administrative duties. The examination is offered twice a year in various locations throughout the country. The medical assistant passing the examination is awarded a CMA (Certified Medical Assistant) pin and may use this title. Medical assistants graduating from an accredited program (determined by the AAMA Curriculum Review Board collaborating jointly with AMA's Department of Allied Health Education and Accreditation) may take the examination immediately after graduation. Those in non-accredited programs must have one year of work experience before taking the examination.

After passing the examination and in order to maintain certification, the medical assistant may either accumulate a certain number of continuing medical education credits (various courses are offered through Illinois Society, the American Association of Medical Assistants for CEU credit) or may retake the certification examination. Either should be accomplished within a five year period.

You can help us achieve an increase in certified medical assistants by urging your assistant to become certified and requesting that all future assistants be certified. If your assistants are certified you can be assured that they are updating their medical education, functioning competently and performing superiorly in the care of your patients.

The next examination will be offered the first Friday in June. The deadline for registration is March 1st. Several texts are available to medical assistants preparing for the certification examination. In addition, a certification review session is offered each year at Harper College in Palatine. The next review session is scheduled for May 26th and May 27th (all day both days).

More information regarding studying for the test or the review session will be available in the next issue of the *Illinois Medical Journal* or may be obtained from Janet Binkowski, RN, 428 Adams Street, Dolton, IL 60419 or Ruby Jackson, CMA, chairman, Public Relations Committee, 7337 South Shore Drive, #625, Chicago, IL 60649. ◀

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Results in 178 Confirmed Cases

Efficacy of Computed Tomography In the Diagnosis Of Herniated Intervertebral Disc

By Leonard Berlin, M.D., F.A.C.R., Gary J. Novetsky, M.D., Avrum J. Epstein, M.D., Sheldon H. Miller, M.D. And Narciso Lobo, M.D./Skokie

During a two year period ending December, 1981, CT examination of the lumbar spine was carried out in a total of 1808 patients. Follow-up was obtained in 769. After omitting those patients who had abnormalities other than herniated discs, or who had no confirmatory procedures, accuracy rates were calculated in the remaining group. Of 97 patients undergoing eventual surgery, CT was correct in the diagnosis of herniated disc in 80%. In the 81 patients eventually undergoing discography and chemonucleolysis, CT correctly established the diagnosis in 90%. After adjusting for eight originally incorrect diagnoses, the adjusted accuracy rate for the combined groups was raised to 89%. Computed tomography is felt to be at least as accurate as myelography in the diagnosis of intervertebral disc disease. It has the advantage of a non-invasive character and can be performed on out-patients. With increasing experience, CT may well replace myelography as the fundamental diagnostic modality in disc disease.

It wasn't until the advent of third and fourth generation geometry that computed tomographic scanning became recognized as an effective tool in the diagnosis of herniated intervertebral discs. Using such equipment, with its higher spatial and contrast resolution, thinner slice thickness and patient localizer, Meyer, Haughton and Williams were the first (1979) to report results of CT scanning in the non-myelographic diagnosis of herniated discs.[1] Following this initial study of 25 patients, the same group published additional reports in 1980.[2,3] Reports of other investigators have since followed;[4-7] these are summarized in Table I.

The purpose of this paper is to report the results of CT scanning in the diagnosis of herniated intervertebral discs in a series of patients considerably larger than that which has appeared previously in the radiologic literature.

Materials and Methods

CT examination of the lumbar spine was conducted on a total of 1808 patients at a computed tomography center during the period from January 1, 1980, to December 31, 1981. Follow-up information on all patients on whom spine CT

Table I
Computed Tomography and Herniated Discs: Review of the Literature

Investigator and Year	Number of Patients with CT Diagnosis of Disc	Number Undergoing Surgery	Accuracy Rate
Meyer *et al* (1979)	25	Not recorded	Not recorded
Williams *et al* (1980)	25	16	100%
Robertson *et al* (1980)	Not recorded	24	63%
Carrera *et al* (1980)	48	29	97%
Livingston *et al* (1980)	Not recorded	79	52%*
Haughton *et al* (1982)	110	55	84%
Williams *et al* (1982)	50	50	100%
Berlin *et al* (1982)	509	97 (Plus 81 Discography)	85%

**Livingston's figures based on second generation CT equipment.*

examinations were performed was requested from each referring physician. Patients who had spine abnormalities other than herniated discs, such as spinal stenosis and tumors, were omitted from this study.

All CT exams were performed on a Pfizer/ AS&E 0450 scanner. A lateral patient localizer was used in every case. Factors were 100 mA, 120 KV, and five second scan time. Pixel size was .5 mm. X-ray beam was aimed parallel to the various interspaces to as great an extent as possible by means of tilting the scanning table to a maximum of 15 degrees. Scan thickness ranged from 2 to 5mm. All scans were interpreted by one in a group of five radiologists.

Criteria used for the CT diagnosis of a herniated disc were similar to those enumerated by Williams, *et al.*,[2,7]: displacement of epidural fat by focal extension of the posterior disc margin, soft tissue mass within the epidural fat, indentation or displacement of the dural sac, calcification within a posterior disc protrusion, and compression or displacement of a nerve root sheath. In addition, several of our cases disclosed soft tissue masses extraforamenally in the expected position of the nerve root sleeves. Examples of typical CT scans are shown (Figures 1-6).

Results

Of the 1808 total spine scans performed, follow-up was obtained in 769. Of these, 35 disclosed either spinal stenosis or tumor and were omitted from this study. In 556 patients, there was clinical follow-up only, without surgery or other confirmatory study; these were also omitted from this report. In 97, patients had subsequent surgery, and in 81, patients eventually underwent discography (all positive) with subsequent chymopapain injection. The surgical procedures were conducted in 35 different Illinois hospitals; discography and chemonucleolysis were performed in hospitals in Toronto, Canada. These latter two groups provided the only objective findings on which to base the accuracy figures which follow. No determination of accuracy in those groups of

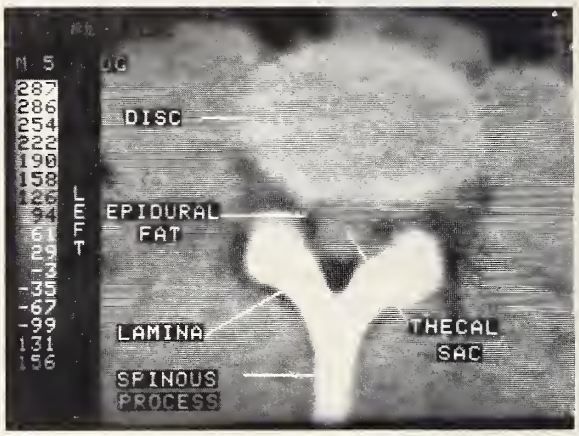


Figure 1
CT scan of normal lumbar disc. Note symmetrical epidural fat surrounding the thecal sac. Anatomic structures are labelled.



Figure 2
Normal lumbar disc. Note the concave configuration of the posterior margin of the disc.

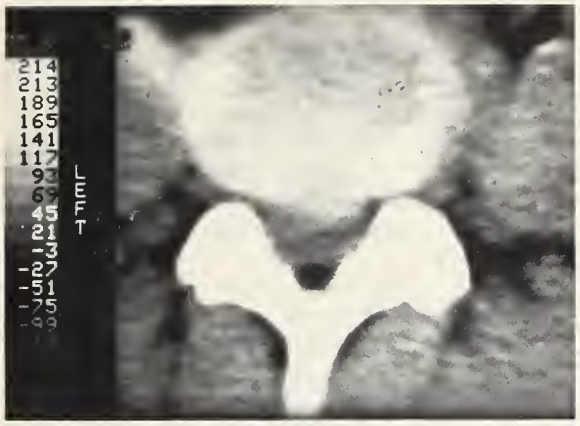


Figure 3
Central herniated nucleus pulposis at L4-5. Note the focal convex protrusion of the disc which indents the thecal sac.

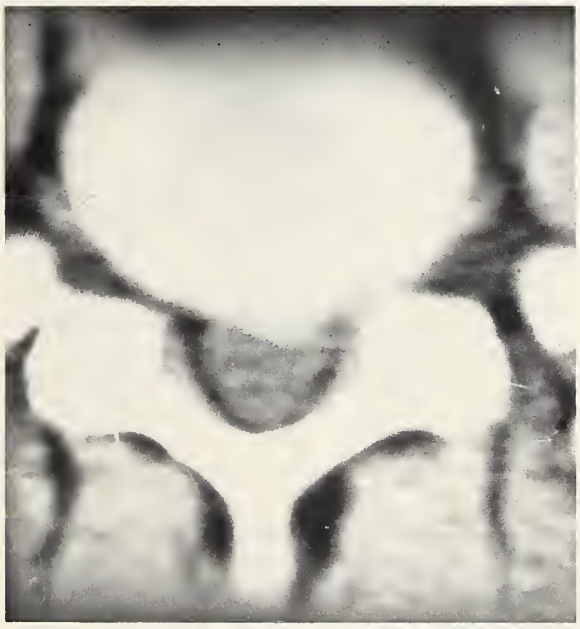


Figure 4
Right central herniated nucleus pulposis at L4-L5.

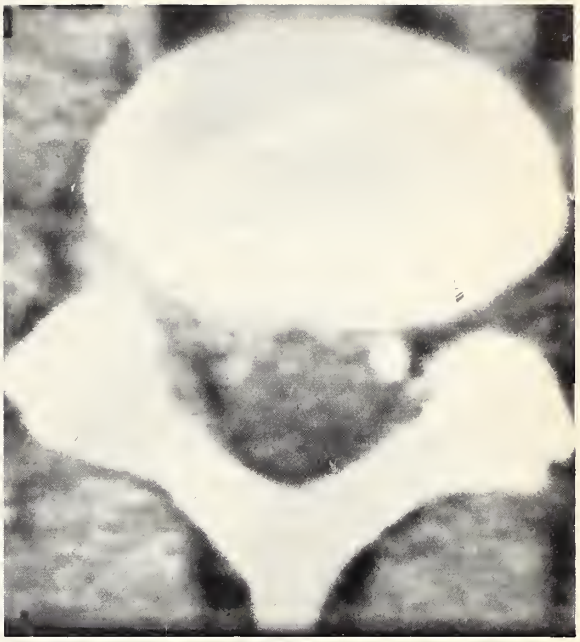


Figure 5
Lateral herniated disc. Note the disc material extending into left neural foramen obliterating epidural fat. The opaque densities in the spinal canal represent pantopaque from previous myelogram.



Figure 6
L5-S1 extruded disc. Note detached fragment of disc in the left side of the spinal canal displacing the thecal sac.

patients who underwent other diagnostic procedures or conservative medical management only, or who were lost to follow-up, could be made. These figures are summarized in Table II.

The CT findings in patients undergoing surgical confirmation are shown in Table III. CT correctly identified the herniated disc in 78 of the 97 patients (80%) who had surgical evidence of a disc. There were two patients in whom a false-positive diagnosis of herniated disc was made, one in whom surgical exploration revealed scar tissue, the other in whom surgery revealed only insignificant bulging disc. Of the 17 false-negative scans, retrospective review showed misinterpretation in seven; these were attributed to early lack of experience. In eight, the technique was felt to be poor, because of patient obesity. Thus, the retrospective accuracy rate was adjusted upwards to 88%.

A summary of CT diagnoses in those 81 patients undergoing eventual discography are listed in Table IV. Discography qualifies as an objective end-point on which to base accuracy rates, since it has been demonstrated, in a 1964 study of 1,786

Table II
Computed Tomography and Herniated Disc
A Two Year Experience

Total Number of Cases: 1808

Follow-up obtained: 769

Non-disc diagnosis: 35

No confirmatory studies: 556

Confirmatory Studies: 178

Surgical: 97

Discographic: 81

Table III
Surgical Confirmation
Total Cases: 97

CT findings	Number of patients	Accuracy rate
Correct diagnosis of Herniated Disc	78	80%**
False-positive diagnosis	2	2%
False-Negative diagnosis*	17*	18%*

Retrospective review of false-negative diagnosis: 7 misinterpreted, 8 poor technique, 2 no change. Adjusted Accuracy Rate increased to 88%.*

proven cases, to itself be 99.2% accurate when compared to surgical findings.[8] CT correctly made the diagnosis of herniated disc in 73 patients (90%). There were no false-positive diagnoses, but there were eight false-negatives. Retrospective review showed one which was felt to have originally been misinterpreted.

Table V summarizes the combined accuracy rates of both groups.

Discussion

The overall accuracy rate of our original CT interpretations, using either surgery or discography as end-points, was 85%. Upon acknowledgement that eight cases were misinterpreted originally, however, the retrospective overall accuracy rate can be adjusted upwards to 89%.

Post-operative epidural fibrosis and bulging annulus accounted for our only false-positive diagnoses. These entities have previously been documented as common causes of false-positive CT interpretations.[2,7] Other conditions which can simulate disc herniation on CT examination include spondylolisthesis and inflammatory processes.[2]

Our false-negative rate seems to have been increased because of a large number of obese patients in our study. We made no restrictions for CT scanning according to patient weight or size. Indeed, some patients were referred to us because they literally could not fit into the gantries of other CT scanners in the Chicago area. The presence of fat is helpful in CT scanning of the abdomen, because its low density supplies a natural contrasting medium to outline anatomic structures. But in CT scanning of the spine, excessive quantities of fat attenuate the X-ray beam, thus limiting the useful information obtained.[2]

In the 556 patients who did not eventually undergo surgery or discography, CT examinations were interpreted as being normal in 200, abnormal in 356. Neither accuracy nor "usefulness" of CT can objectively be assessed in this group, but nevertheless, physician follow-up indicated that the CT scans were extremely helpful in the patient management.

Correlation of CT with myelography was not evaluated in this report, but others have found these two modalities to be equally accurate in the diagnosis of herniated discs.[6] It should of course be emphasized that in distinction to myelography, computed tomography is a non-invasive procedure that can be performed on out-patients.

Summary

An overall accuracy rate of 85% was recorded in 178 patients with herniated intervertebral discs who underwent CT scanning prior to surgery or discography. Correction of several original mis-

Table IV
Discography Confirmation
Total Cases: 81

CT findings	Number of patients	Accuracy rate
Correct diagnosis of herniated disc	73	90%
False-negative diagnosis	8	10%
False-Positive diagnosis	None	

Table V
Summary of Overall Results
Surgical and Discographic Confirmation

Number of Patients	Diagnosis Correct	Accuracy Rate	Adjusted Accuracy Rate*
178	151	85%	89%

**Retrospective review disclosed 8 errors in initial interpretations. Adjusted rate reflects 159 correct diagnoses instead of 151.*

interpretations increased this rate to 89%. Computed tomography is an extremely effective diagnostic modality in herniated disc disease, it is non-invasive and requires no hospitalization. As experience with this modality increases around the nation, CT may well replace myelography as the fundamental method in establishing the diagnosis of herniated disc disease. ◀

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WARNINGS

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IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY: Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System*: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal*: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic*: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory*: bronchospasm. *Hematologic*: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous*: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings*: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

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TEENAGE DRINKING

By Mrs. Don Hinderliter ISMSA President

A 1973 national survey on the use of alcohol revealed that 93% of boys and 87% of girls in their senior year of high school had experimented with alcohol and more than half of the country's seventh graders had tried drinking at least once during the previous year.[1] One study of the degree of adolescent drinking was reported by the Center for Study of Social Research Triangle Institute.[2] This study was based on a sample of 13,122 junior and senior high school students in grades 9-12 nationwide. Some of the findings included: (1) 54.8% of all adolescents drink at least once a month; (2) beer is the average choice for those drinking once a month or more; (3) 80% of adolescents have had at least one drink and 74% have had 2-3 drinks. Almost all surveys show boys drinking more than girls, but girls seem to be drinking as early as boys at the present time.[3]

The San Mateo Study[4] shows that 8.2% of seventh grade girls reported the use of alcoholic beverages on 10 or more occasions in 1969 and by 1974 the percentage was 19.7%.

Alcohol is absorbed into the bloodstream from the gastrointestinal (G.I.) tract. The rate of absorption depends on several things, such as presence of food in the stomach, concentration of alcohol being drunk, volume of consumption, and length of drinking time. The liver can metabolize or eliminate from the body one ounce of absolute alcohol per hour without effecting the central nervous system (CNS). Alcohol depresses the CNS and impairs memory, judgment, and coordination. When the blood alcohol content (BAC) reaches 1000mg/l the individual may talk very loudly and inhibitions are reduced. A BAC at 2000mg/l will cause an individual to exhibit ataxia, stupor and eventual unconsciousness. Because the brain is a very vascular area and alcohol has the ability to cross the blood-brain barrier, the CNS is especially susceptable to alcohol's effects. 500,000 deaths and 5 million injuries have occurred in this nation during the past twenty years, all caused by alcohol-impaired drivers.[5] If adolescents begin to learn early that they cannot drink and drive, many lives could be saved and debilitating injuries avoided.

Alcohol use among the youth has reached epidemic proportions (at least in my community). So what can aware auxilians do in their communities to stem this problem? The key to prevention is education. Alcohol education should be a part of every curriculum and should begin in elementary school, not in junior high. As a concerned auxilian you can contact your school system and inquire what education is offered on this subject. Seek to determine who is teaching it, whether the schools welcome literature, what curriculum it is identified with and other details. Once a rapport is established, it is much easier to return with your ideas and/or materials.

Effective education begins with the teacher who must have come to terms with his/her own feelings about alcohol.[6] We cannot control whether or not adolescents drink. It is the role of the educator, auxilian or teacher, to present the facts, both positive and negative, and help them make intelligent choices about drinking alcoholic beverages.

The facts about alcohol can be taught through role playing, with art, through music or various other creative and interesting ways. Adolescents must be able to recognize alternatives, make decisions, and accept the consequences of those decisions. It is the role of the educator to give reliable information and enable intelligent choices.

Parents also need information on how they can say no to having beer parties in their homes. Joliet Catholic High School has produced a booklet en-

titled, "Parties: A Practical Guide For Parents"[7] which offers guidelines on hosting a party, attending a party, curfews, and facts on alcohol and the law. This booklet contains common sense information on handling this problem.

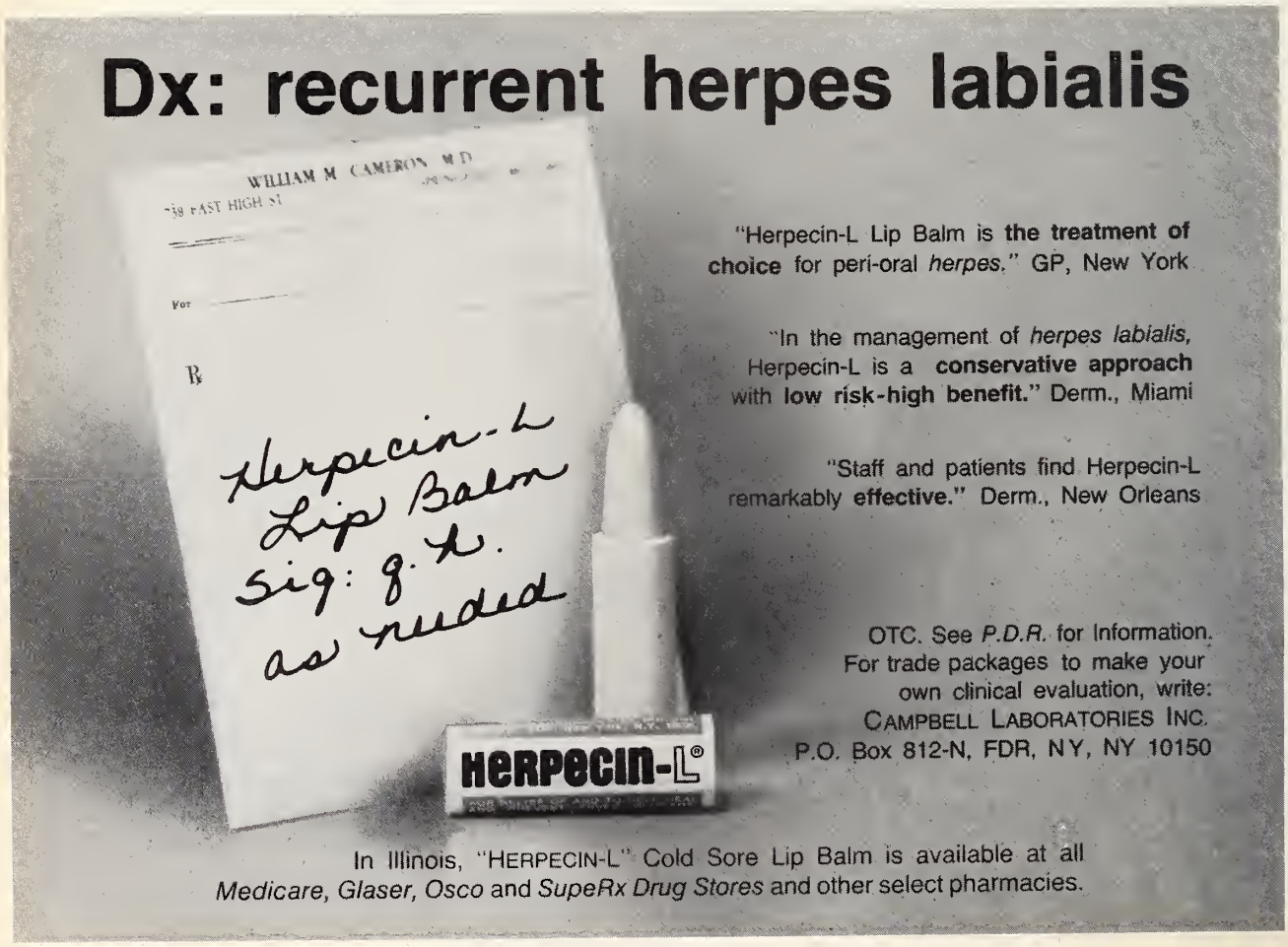
Project PRC[8] (Prevention Resource Center) has services it can provide for your community. These services include: on-site consultation and training workshops, library and information resources, special project involvement, prevention forum and speaker's bureau.

The National PTA[9] has taken an in-depth look at the problem of alcohol use and abuse among adolescents through its Alcohol Education Project. They also have materials for use by parents, teachers, students, health officials, and community groups.

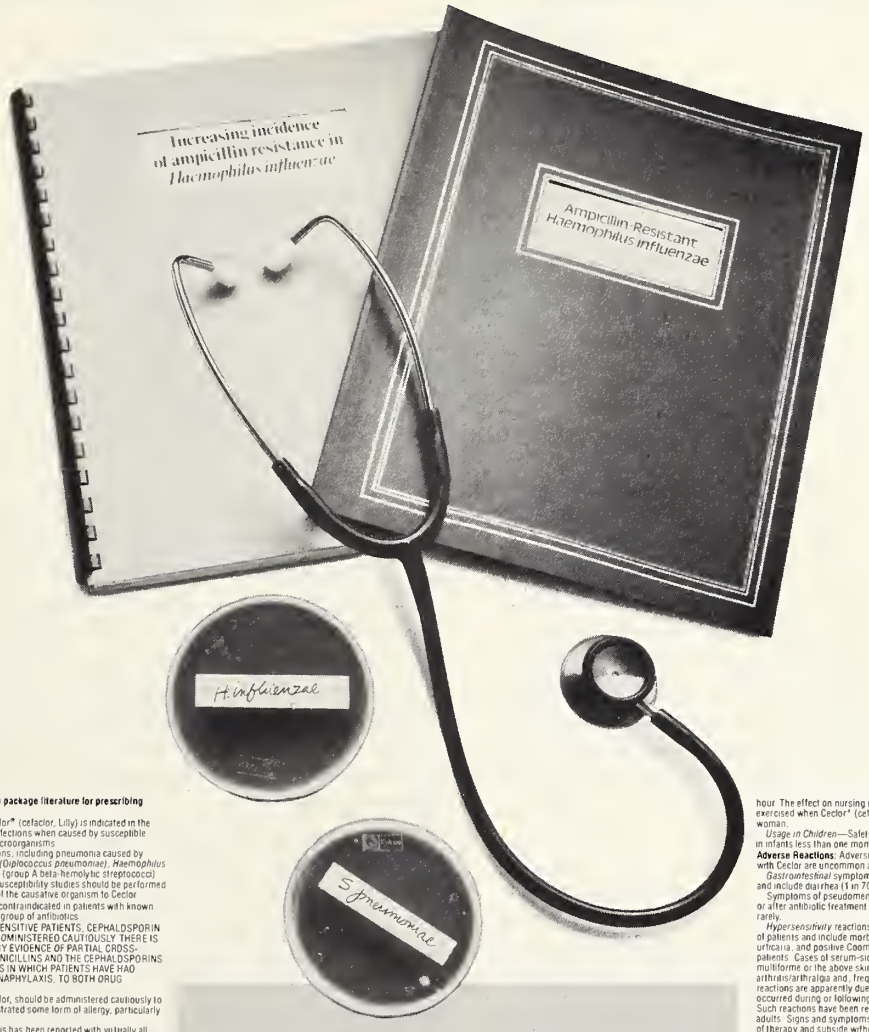
There is much auxilians can do if they choose to contribute their efforts in this area. It is not a problem that can be eradicated easily. There are no panaceas, but education is certainly the key to aid adolescents in making intelligent choices about alcohol use. ◀

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given thirteen times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

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* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Common Causes of Treatment Failure In Scabies

By Walter B. Shelley, M.D. and E. Dorinda Shelley, M.D./Peoria

Scabies in patients who bathe frequently is often difficult to recognize, leading to lengthy delays in diagnosis and treatment. The persistence of itching after treatment with a scabicide may further complicate the clinical picture, casting doubts on both diagnosis and treatment. As an aid in diagnosis, we recommend cessation of bathing for one week and use of the ink test to spot burrows. Treatment should include simultaneous applications of a scabicide to the entire skin surface of the patient and all family members and close contacts. No more than three applications of the scabicide should be allowed. Additional treatment with topical steroids and systemic antibiotics will help heal the skin in severe cases.

Scabies is eminently treatable.[1] The physician is confronted not with a derangement in molecular biology, not with invisible, adaptive microorganisms, but with a relatively few ectoparasites, situated only in the outermost layer of the skin surface. These parasites can be promptly killed by several contact poisons which may be applied topically by the patient. It would seem there should be no treatment failures, and yet there are. Why? In our referral experience, these are the four common significant reasons.

Failure to Recognize Scabies

Most physicians "think" scabies in the patient with a generalized itch that is worse at night, is shared by others in the household and shows the tell-tale burrow between the fingers. But scabies can present itself as no more than an itch. In the well-washed person, this is especially true, as most of the mites have been mechanically washed away. Those mites resting in their stratum corneum nesting tunnel may be ripped off by the fingernail in response to a focal itch. The physician sees only the non-specific excoriations. A mere one or two mites may remain, completely inapparent, in some privileged site such as the umbilicus, still ready to propagate. It takes only one fertile female acarus to transfer or to maintain the infestation.

Some cases of scabies are missed because the lesions mimic eczema or folliculitis. Papular eruptions are common and may be so extensive as to cover the entire skin surface. At other times, they may be limited to the buttocks. Some papular examples suggest persistent insect bites (and in a manner of speaking, they are just that). In the individual with poor hygiene, crusted thick keratinous responses may be seen on the hands. In a few instances, sophisticated dermatologic diagnoses such as dermatitis herpetiformis, or Mucha-Habermann's disease have blinded the physician to the true nature of the problem. In all patients with scabies, the possibility of an obscuring bacterial infection is also present.

Some physicians miss scabies because they depend on a history of other family members with a similar problem. The source of the parasitism may be completely unknown. Teachers or others in contact with children are at special risk for this disease. Scabies is also a hazard for those who are in nursing homes for the elderly, where little-publicized epidemics occur. In any event, the contact history may be inadequate or simply incorrect.

The failure to recognize scabies is avoided by having a high index of suspicion whenever a pa-

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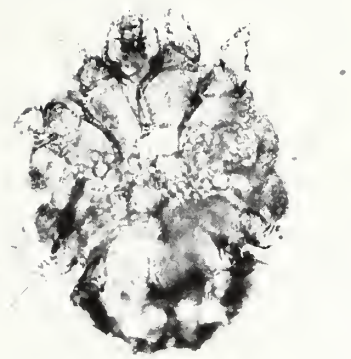


Figure 1

Ventral view of adult female of *Sarcoptes scabies*, the cause of scabies. This mite, a barely visible speck in size, may make a characteristic winding, thread-like burrow a centimeter in length. Fortunately for the patient, the burrow provides no protection from the lethal effects of a single application of lindane or crotamiton.

tient has an unexplained chronic itch. Such suspicion demands careful inspection for the diagnostic burrow in the favored sites of the interdigital webs, axillary folds, nipples, or umbilicus. If no burrow is evident on direct inspection, we have used two approaches with success. The first is to apply a dye such as ink from a fountain or marking pen over sites of dermatitis.[2] This is then wiped off with alcohol, revealing the tiny dark thread-like burrows into which the dye has entered by capillarity. Such a burrow lifted off by a single superficial stroke of a razor blade and placed on a glass slide, will reveal the mite, eggs or reddish-brown fecal concretions when viewed at low power in xylene or potassium hydroxide under a cover slip.[3]

An alternate approach is to have the patient completely abstain from bathing for one week, giving the mites relative immunity for this period. Upon return, the patient often has new lesions which are grossly diagnostic. The patient furthermore should be encouraged to become less compulsive about digging out each lesion, so that typical lesions may be identified.

Failure to Treat the Entire Skin Surface

We have seen repeated examples of treatment failure due to "spot" treatment of the lesions. It is not adequate to apply a scabicide, such as lindane 1% (Kwell®) or crotamiton (Scabene®) lotion or cream solely to the pruritic areas. Even the pharmaceutical ads fail to mention this caveat. Since the mites are migratory, every square centimeter of skin, normal or abnormal, must be treated to assure a cure. The only exceptions are the face and scalp, although, even these must be treated, if lesions are present. The face and scalp are usually spared due to the apparent dislike of the mites for sebum-rich skin.

Recall that the mite is truly a pin-point target traveling over a two-square meter playing field. The possibility of missing this target during treatment demands that the treatment be reapplied twenty-four hours later. The back is a particularly difficult zone in this regard. Furthermore, the parasiticide should not be washed off in the interim. In infants and young children, an abbreviated contact time of twelve hours is advised to avoid excessive absorption through their highly permeable skin.

We prefer to use lindane lotion, for ease of application and for its capacity to enter and remain in the burrow. Burrows so treated become a lethal chamber for any larva coming out of the eggs days later. One additional treatment in seven days is sometimes advisable if new lesions are suspected.

Failure to Treat Close Contacts Simultaneously

The scabies mite is capable of moving from person to person, especially given skin to skin contact. It is therefore imperative that sleeping partners, family groups, or nurses involved be treated at the same time as the patient. This must be done whether or not the contacts complain of itch. Itching is the sign of an immune sensitivity to the mite, not to the physical presence of the mite. Accordingly, it may be *weeks* before an infested person begins to itch. Without such epidemiologically-based therapy, scabies will undoubtedly return to your patient.

The mite usually is not transferred by bedding, but it can be. In one serious recurrent epidemic of scabies in a large nursing home, success in management did not come until the mattresses of the affected patients were discarded.

Failure to Stop Antiscabetic Treatment

Two treatments at a twenty-four hour interval is curative of scabies in most cases. For those who prefer the security of both belt and suspenders, a third treatment a week later may be given. But that is all. Only the appearance of new burrows, microscopically confirmed, can justify further treatment. New lesions should suggest that some infested contact has *not* been identified and treated.

The post-scabetic itch is common and not a sign of need for further antiscabetic treatment. Despite the patient's fear and worries, all that itches after treatment is not scabies. The patient must be instructed that further treatment with lindane may aggravate the itch or produce irri-

tation. Interestingly, crotamiton is an antipruritic, but it, too, should not be continued.

The patient must be reassured that the mites have been destroyed. There must be a clear understanding that the skin at this time is in a temporary hyperalgesic pruritic state. The use of topical steroid creams or ointments is now indicated, but not before this. Many cases of active scabies have been made worse by suppression of cutaneous defense mechanisms with a topical steroid.

Atopics are particularly in need of help with post-scabetic pruritus. For them a systemic antibiotic such as erythromycin is particularly helpful in healing infected excoriations.

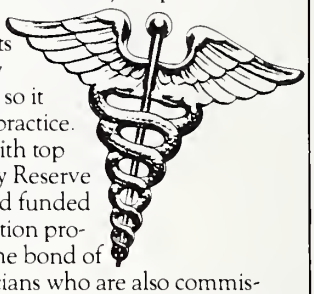
Avoiding these four causes of failure can insure that your patient with scabies won't seek a "second opinion."

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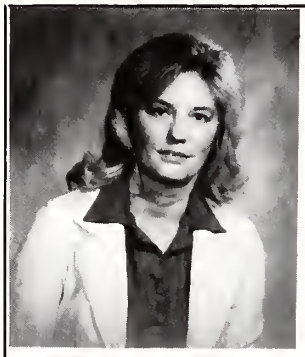
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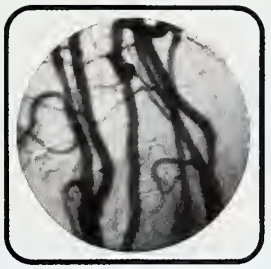


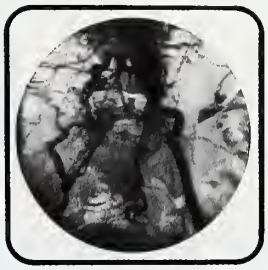
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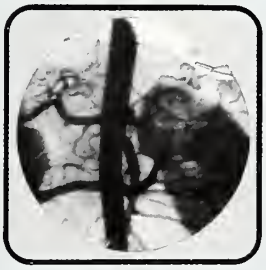
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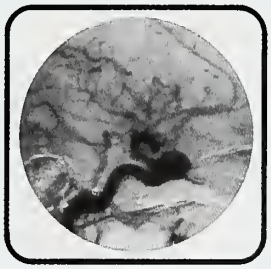
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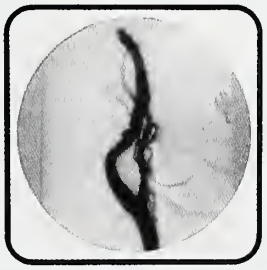
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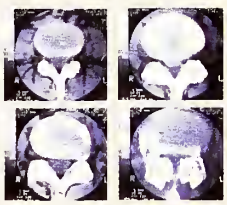
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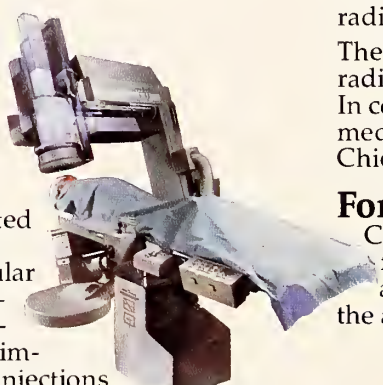
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Rheumatology Rounds

L. F. Layfer, Contributing Editor

Seronegative Spondyloarthrophy II

Psoriatic Arthritis

A 28-year-old dentist was seen for unilateral knuckle pain. Symptoms had begun three years earlier with pain and swelling of the second metatarsophalangeal (MTP) joint of his left foot and second and third proximal interphalangeal (PIP) joints of his right hand. Swelling of the right knee developed three months later. Psoriasis had then been present for five years and a diagnosis of psoriatic arthritis was made. Failure of indomethacin led to gold therapy with resolution of all complaints. Gold was stopped two years after initial visit, when the patient relocated.

Six months later he noted onset of swelling in the fourth distal interphalangeal (DIP) joint of the left foot and the third PIP/MCP of the left hand. He was taking four ASA per day on his own. Past history was otherwise unremarkable. Psoriasis was confined to his elbows and was not under active treatment. He denied urethritis, eye irritation, bowel dysfunction, V.D., mucosal ulcerations or low back pain. He was left handed.

Examination revealed psoriatic plaques about both elbows, and near his hairline. Nail pits were not observed. Swelling at the third PIP/MCP on the right hand was observed, as well as the flexor tendon between them. Limitation of motion without pain or swelling was noted in the third PIP of the right hand at the site of old inflammatory disease. No subcutaneous nodules were observed. The left fourth DIP toe was red and tender. Other examination was unremarkable.

Laboratory

SMA-18, complete blood count, urinalysis, electrocardiogram and chest X-ray were unremarkable. Rheumatoid factor, antinuclear antibodies and HLA-B27 antigen had been absent in the past and were not repeated. X-ray of the left hand revealed soft tissue swelling about the third PIP/MCP without erosion. No periosteal reaction was noted. Foot X-rays were unremarkable.

Discussion

Inflammatory arthritis occurs in approximately seven percent of patients with psoriasis. Synovial biopsy reveals an inflammatory pattern similar to that seen in rheumatoid arthritis. However, psoriatic arthropathy can often be distinguished from that of rheumatoid arthritis on both a clinical and laboratory basis. Several types of presentations occur. Most common, found in 70% of patients with arthropathy, is an asymmetric, mild mono or oligo arthritis involving most often the knee, ankle, elbow or small joints of the hands and feet. Onset is usually insidious, leading to chronic disease. However, it may be acute and is sometimes explosive, resembling infectious or crystal arthropathy. Involvement of the DIP joint is characteristic but not invariable. Flexor tendon involvement or a periostitis (dactylitis) may occur, and in conjunction with adjacent small joints present a "sausage" digit, or diffuse swelling of a phalangeal segment. Soft tissue involvement may also occur about the achilles tendon or the plantar fascia, causing heel pain. Although psoriatic arthropathy is generally milder than in rheumatoid arthritis (RA), rapid and severe destruction may supervene. This is especially true



Figure 1
Disease is noted in three small hand joints (arrow). Note "pencil in cup" deformity of both thumb joints with subluxation of the distal thumb joint.

of the hand joints (arthritis mutilans), where X-ray reveals a "pencil with cup" deformity and "whitting" of terminal phalanges (Figure 1). Another presentation is a polyarticular symmetric distribution of a large and small joint pattern of inflammation resembling RA. These patients are seronegative, are without nodules, and lack the systemic complications of RA. It is well to remember, however, that RA and psoriasis can and do occur independently in any individual patient.

Finally, spondylitis similar to that seen in ankylosing spondylitis can occur in up to 40% of psoriatics with arthritis, and seems to be independent of the peripheral joint disease. In most such patients, disease is confined to the sacroiliac joints only. It may ascend the spine, however, to the lumbar or cervico-thoracic areas. X-rays usually show asymmetric and sporadic syndesmophytes, but the full "bamboo" spine of ankylosing spondylitis can occur. Clinically it manifests itself as low back pain with variable degrees of upper spinal pain and restricted mobility. HLA-B27 is seen in 60-90% of psoriatic spondylitics, and is noted in up to 20% of those with peripheral joint disease (five percent in NML population).

The relationship between skin and joint disease is unclear. Patients with worse skin disease seem to have a higher incidence of arthritis, and in some, exacerbations and remissions of each can be correlated. It is well to remember, though, that 15% of psoriatic arthritics have skin changes that begin only after the onset of joint disease, and that disease, even when present, may be mild or hidden in the scalp, behind the ears, or in the umbilicus or gluteal folds. These patients are often labeled "seronegative RA" until the skin changes become manifest. Nail bed changes may afford additional clues to the diagnosis of psoriatic arthritis: pitting of the nails or onycholysis are more often found in psoriatics with arthritis than without (80% vs 20%).

Laboratory investigations reveal neither rheumatoid factor nor antinuclear antibodies, and normal complement levels are present. Joint fluids have variable inflammatory changes like that of RA. Prognosis is good and most patients maintain a good level of function. Therapy begins with non-steroidal agents, as in RA. Local cortisone injections and physical therapy are used as adjuncts when appropriate. Persistant or polyarticular disease unresponsive to the above will often respond to gold or cytotoxic agents like methotrexate and should be applied when the clinical situation warrants it.

Conclusion

Recurrence of the psoriatic arthritis was thought to be the likely cause of asymmetric small joint inflammation in this left handed dentist, most likely related to the stoppage of the gold. Indomethacin 50mg q.i.d. was tried without significant relief of hand symptoms. Sterile triamcinolone hexacetonide suspension ½cc was then injected into the involved MCP, PIP and flexor tendons of the left hand with an excellent response. Except for a right knee flare, also successfully with an sterile triamcinolone hexacetonide suspension injection, he has been maintained on indomethacin 50mg t.i.d. for three months without other recurrences.

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A complete bibliography may be obtained by writing the editor, Lawrence L. Layfer, M.D.: Rheumatology Associates, S.C., Rush-Presbyterian-St. Luke's Professional Building, 1725 W. Harrison Street, Chicago, IL 60612.

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Special Articles

The Extent of Physician Participation In Continuing Medical Education Activities

By Linda K. Gunzburger, Ph.D./Maywood

This study of Illinois physician learning activities was first presented at the 1981 session of the Association of American Medical Colleges Twentieth Annual Conference on Research in Medical Education.

The purpose of this study was to contact Illinois physicians who are members of the Illinois State Medical Society (ISMS) and determine the type and frequency of their continuing medical education (CME) activities. Differences were found, dependent on type of medical practice and location of that practice within the State of Illinois. The study was prompted from the pressing need facing CME planners to consider seriously the viability of various learning programs for particular physician audiences within their localized settings. Ten percent of the ISMS membership was randomly selected according to zip code from the Illinois State Medical Society's membership and sent a copy of the *Activities Survey*, an instrument for measuring the extent physicians participate in continuing medical education during both leisure and work time. This study found that both location and practice significantly influenced responses on the *Activities Survey*.

LINDA K. GUNZBURGER, Ph.D., is associate dean for Education Research and Development and director of the Division of Continuing Medical Education at the Foster G. McGaw Memorial Hospital, Loyola University Stritch School of Medicine. A specialist in curriculum evaluation and professional education, she is a member of the Board of Directors of the Illinois Council on Continuing Medical Education and an educational consultant for the Illinois Cancer Council.

Results from the study include a useful description of CME activities participated in most and least frequently. Based on the physicians' current learning activities, continuing education activities can be arranged to meet the needs of physicians located throughout Illinois in different areas of practice. The survey produced four tables which list each practice area and location in the state. These tables illustrate the kinds of activities physicians select for their continuing learning.

Background

Monumental advances in technology and the swift pace of twentieth century life have brought about the need for more continued learning among various professionals and non-professionals. The medical profession has been particularly affected by these developments.

Numerous studies have attempted to determine trends and reasons for participation in continuing education generally and CME in particular.[1-8] The basic conclusion to be drawn from these studies is that learners participate in continuing education for various and sometimes multiple reasons, some of which may be unrelated to the educational content.[9]

Despite the move toward more learner-oriented, participatory educational activities among CME planners, some studies still show that lecture methods and professional reading are the preferred means of attaining a learning goal.[10-14] Other findings from these studies showed that physicians

spend anywhere from 22-54 hours per month on CME activities,[12,14,15] and that lack of time/patient load [10,15] and loss of income from practice[14] are offered as significant factors which detract from CME participation.

The Illinois Council on Continuing Medical Education[9] had conducted a factor analytic study dealing with reasons for CME participation. This investigation found that physician reasons for participation in CME fell into four general factors.

Table 1
UPSTATE

Specialty (CMEIN Average)	High Factors	Low Factors
Pathology (12823)	Contributing papers for presentation or publication Teaching Participating in committee meetings Using different medical resources	Referring patients Inquiring about new drugs or medical procedures
Obstetrics & Gynecology (10932)	Referring patients Inquiring about new drugs or medical procedures Using different medical resources Participating in committee meetings	Teaching Contributing papers for presentation or publication
Surgery (9647)	Participating in Committee Meetings Practice alone in building housing other physicians Contributing papers for presentation or publication	Attending state or local CME meetings Using different medical resources
Unknown (8781)	Practice alone in building housing other physicians Referring patients Participating in committee meetings	Attending CME national meetings Teaching
General & Family Practice (7853)	Referring patients Attending CME at national meetings	Teaching Attending state or local CME meetings
Anesthesiology (7705)	Practice alone in building housing other physicians Attending state or local CME meetings	Teaching Attending CME national meetings
Internal Medicine (7325)	Referring patients Inquiring about new drugs or medical procedures	Using different medical resources Attending state or local CME meetings
Psychiatry (4999)	Attending CME national meetings	Attending state or local CME meetings Inquiring about new drugs or medical procedures
Neurology (0)		
Opthalmology & ENT (0)		
Others (0)		
Pediatrics (0)		
Radiology (0)		

CMEIN = CME Index. The maximum possible CMEIN = 32208

Table 2
MIDSTATE

Specialty (CMEIN Average)	High Factors	Low Factors
Ophthalmology & ENT (11887)	Contributing papers for presentation or publication Practice alone in building housing other physicians Attending state or local CME meetings Inquiring about new drugs or medical procedures	Teaching
Surgery (11689)	Contributing papers for presentation or publication Referring patients Attending state or local CME meetings Teaching	Practice alone in building housing other physicians Using different medical resources
Pathology (10375)	Participating in committee meetings Inquiring about new drugs or medical procedures Attending state or local CME meetings	Referring patients Teaching
Obstetrics & Gynecology (10272)	Attending state or local CME meetings Participating in committee meetings Practice alone in building housing other physicians	Teaching Contributing papers for presentation or publication Attending CME national meetings
Anesthesiology (9551)	Attending state or local CME meetings Teaching	Participating in committee meetings Practice alone in building housing other physicians
General & Family Practice (9043)	Participating in committee meetings Attending CME national meetings	Teaching Using different medical resources
Pediatrics (8768)	Practice alone in building housing other physicians Attending state or local CME meetings	Attending CME national meetings Using different medical resources
Internal Medicine (8702)	Practice alone in building housing other physicians	Attending CME national meetings Attending state or local CME meetings Inquiring about medical procedures
Radiology (8376)	Contributing papers for presentation or publication	Referring patients Participating in committee meetings Attending CME national meetings
Psychiatry (0)		

CMEIN = CME Index. The maximum possible CMEIN = 32208

Table 3
DOWNSTATE

Specialty (CMEIN Average)	High Factors	Low Factors
Pediatrics (14711)	Teaching Contributing papers for presentation or publication Referring patients	Inquiring about new drugs or medical procedures Participating in committee meetings
Obstetrics & Gynecology (10601)	Attending state or local CME meetings Practice alone in building housing other physicians Participating in committee meetings	Teaching Using different medical resources Contributing papers for presentation or publication
Internal Medicine (9875)	Inquiring about new drugs or medical procedures Contributing papers for presentation or publication	Teaching Practice alone in building housing other physicians
General & Family Practice (9147)	Referring patients Participating in committee meetings Inquiring about new drugs or medical procedures	Teaching Contributing papers for presentation or publication
Surgery (8529)	Participating in committee meetings Practice alone in building housing other physicians	Inquiring about new drugs or medical procedures
Unknown (7346)	Inquiring about new drugs or medical procedures Using different medical resources	Participating in committee meetings Referring patients Teaching
Ophthalmology & ENT (5341)	Inquiring about new drugs or medical procedures Attending CME national meetings Referring patients	Participating in committee meetings Using different medical resources
Anesthesiology (0)		
Neurology (0)		
Others (0)		
Pathology (0)		
Psychiatry (0)		
Radiology (0)		

CMEIN = CME Index. The maximum possible CMEIN = 32208

These were (1) to maintain and improve professional competence and service to patients; 2) enhance personal and professional position; 3) understand oneself as a professional; and 4) interact with colleagues.

Since the question of CME participation is multifaceted, it is essential for CME planners to consider seriously the nature of viable CME learning activities within their localized settings. The issue is compounded by the spiraling costs of conducting CME as well as competition among CME providers and resentment among many consumers evoked by mandatory CME. Based on these issues the current study seeks to further define the kinds of CME programs selected by Illinois physicians and to what degree individual physicians participate in them.

Study

The purpose of this study was to investigate Illinois physicians who are members of ISMS and determine the type and frequency of their con-

Table 4
CHICAGO

Specialty (CMEIN Average)	High Factors	Low Factors
Radiology (12233)	Attending state or local CME meetings Contributing papers for presentation or publication	Referring patients Practice alone in building housing other physicians
Obstetrics & Gynecology (11799)	Using different medical resources Referring patients Participating in committee meetings	Practice alone in building housing other physicians Attending CME national meetings
Anesthesiology (11388)	Attending state or local CME meetings Contributing papers for presentation or publication	Participating in committee meetings Practice alone in building housing other physicians
Pathology (11273)	Using different medical resources Attending CME national meetings Attending state or local CME meetings	Referring patients Practice alone in building housing other physicians
Neurology (11105)	Teaching Contributing papers for presentation or publication Practice alone in building housing other physicians	Participating in committee meetings Inquiring about new drugs or medical procedures
Surgery (10489)	Contributing papers for presentation or publication Participating in committee meetings Inquiring about new drugs or medical procedures	Attending CME national meetings Attending state or local CME meetings
Pediatrics (10338)	Attending CME national meetings Practice alone in building housing other physicians Teaching	Referring patients Participating in committee meetings
Internal Medicine (10202)	Teaching Referring patients	Attending state or local CME meetings Attending CME national meetings
General & Family Practice (10159)	Attending CME national meetings Referring patients	Contributing papers for presentation or publication Teaching
Psychiatry (9542)	Practice alone in building housing other physicians Teaching	Inquiring about new drugs or medical procedures Contributing papers for presentation or publication
Ophthalmology & ENT (8685)	Practice alone in building housing other physicians Teaching	Attending CME national meetings Participating in committee meetings

CMEIN = CME Index. The maximum possible CMEIN = 32208

tinuing medical education activities. In particular, the study addressed the following research questions:

- What are the CME activities in which Illinois physicians participate?
- Although physicians select different activities, is the "quality of their CME involvement" similar?
- Does location in the state or type of medical practice influence the amounts of time spent by physicians in different types of activities?
- Does location in the state or type of medical practice influence the selection of CME activities?

Instrumentation

Physician respondents in the study completed the *Activities Survey*[16] which measured their degree of participation in continuing medical education during leisure or work time. This instrument provided each physician with a continuing medical education index which identified the extent of his/her involvement in continuing medical education activities. This index represented "the quality of CME involvement" as shown by the number of activities, the educativeness of various activities, and time spent on each activity. The reliability of the *Activities Survey* was .9547 significant to 0.1 percent.

Sample

Physicians were ramdomly chosen according to zip code, so that a 10% sample of members from across the state was selected. Each of these physicians from the sample was sent a copy of the *Activities Survey* and was asked to complete the instrument and return it for analysis. A total of 417 physicians in Illinois returned the *Activities Survey*. Seventy percent of them were from the Chicago area, 16% from midstate, 7% from upstate, and 7% from downstate. Several types of practice were represented in the sample. These include surgery, general and family practice, internal medicine, radiology, obstetrics & gynecology, psychiatry, pediatrics, ophthalmology & ENT, anesthesiology, pathology, and neurology.

Methods

1. For each of the 68 activities listed on the *Activities Survey,* the percentage of respondents who selected each particular answer was calculated.

2. The continuing medical education index (CMEIN) was calculated for each of the 417 respondents.

3. Using location and type of medical practice as independent variables, analyses of variance were calculated to determine if physicians spent similar amounts of time in learning activities.

4. After completing factor analyses of the 68 activities, factor scores for each subject were calculated. These analyses determined whether physicians from different locations or in different types of medical practices participated in different types of activities. Throughout the course of this investigation a .10 level of significance was used.

Results

Concerning the question of which CME activities Illinois physicians engaged in most frequently, the following were among those selected by 90% or more of the respondents: Read a medical magazine (98%), discussed a case with a colleague (97%), attended a medical lecture (97%), used books as a medical resource (96%), checked medical resources after examining a patient (93%), read an article in the *Journal of American Medical Association* (92%), referred a patient to a specialist (91%), telephoned another physician for consultation (91%), and read a pharmaceutical company's literature regarding pharmacology advances (90%).

Some activities in which 10% or fewer of respondents participated were: Completed a mini-residency (7%), contributed to a medical book for publication (7%), completed a clinical traineeship (8%), and attended CME courses at an international meeting of a medical society (9%).

Using location and practice as independent variables, ANOVA (Analysis of Variance) for CMEIN was applied to determine if the respondents' CME indices showed significant differences. Both "location" and "practice" effects were within the .10 level of significance and there was no significant interaction effect between location and practice.

The grand mean of CMEIN for total respondents was 10086. Based on calculated adjusted deviations from this mean, physicians from the Chicago area had the highest CMEIN. Those from midstate had the second highest, those from downstate third, and physicians from upstate had the lowest CMEIN.

The physicians in different types of medical practice also showed differing CMEIN scores. Respondents in pathology, radiology, and obstetrics and gynecology had the highest CMEIN. The physicians in psychiatry, ophthalmology, ENT and "other" practices had the lowest CMEIN. The physician groups whose CMEIN approached the mean were, in descending order: neurology, anesthesiology, surgery, pediatrics, general and family practice, and internal medicine.

Using location and medical practice as independent variables, ANOVA was applied to time values for each activity. Sixteen activities had significant "location effects" ($p<.10$), *i.e.*, physicians from different locations in Illinois spent different amounts of time in each of these 16 activities. Thirty-seven activities had significant "practice effects", *i.e.,* physicians in different practices spent different amounts of time in each of these 37 activities. A total of 12 activities were found to have both significant location and practice effects.

After applying factor analysis to 42 selected activities, 14 factors were obtained. Factor scores for each respondent were calculated. ANOVA was applied to these 14 factor scores, using location and practice as independent variables. Results of this procedure showed that nine factors had significant location and/or practice effects and accounted for a total explained variance of .84.

These nine factors, named for the activities having highest loadings within that factor, are the following: teaching, contributing papers for presentation or publication, attending state or local CME meetings, inquiring about new drugs or medical procedures, attending national CME meetings, participating in committee meetings, referring patients, practicing alone in buildings housing other physicians and using different medical resources.

This discussion describes the relative correlations of the various medical practices and locations with each of the nine factors. Four tables were formulated to better visualize the findings. Each of the tables lists the results of a specific location. The physicians participating in continuing learning activities are listed by practice area, and findings are reported in terms of the greatest CME involvement to least. In addition, the type of activities a physician chooses are reported. Such a table is helpful to local and state medical planners in providing appropriate activities for physicians. (See Tables 1, 2, 3, and 4.)

Discussion and Conclusion

The findings of this study are important because the extent to which physicians participate in different continuing medical education activities are clearly identified. It was found that physicians in different areas of the state and in different practice areas had differing CME involvements. In addition, for all continuing medical education activities, nine factors were shown which illustrated location or type of practice effects. This enables the CME planner to identify types of activities in which particular groups of physicians are most likely to participate. Currently, the kinds of activities planned for particular areas of the state can be reviewed to determine if this corresponds with actual CME involvement of local physicians.

Considering the number of CME programs offered annually in the state and the accompanying costs, a descriptive study such as this could have significant impact in the design and development of future CME programs. Although there is little empirical proof that certain CME programs are inherently of greater quality or benefit than others, the present study could offer a statewide perspective on the viability of particular CME curricular areas and assist local programmers in selecting CME activities. ◀

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ISMS 1983 Travel Programs

The following ISMS-sponsored programs have been scheduled for 1983:

March 16—*Caribbean Air/Sea Cruise:* St. Thomas, Antigua, Barbados, Martinique and St. John

May 29—*Dutch Waterways:* two week holiday including cruise of the canals and inland sea of Holland, plus Paris and Geneva.

June 28—*Orient Express:* Vienna, Venice, the Orient Express Train and Paris

July 28—*Main River:* Wiesbaden, six nights cruising on the Main River and Munich

August 14—*Canadian Rockies:* ten day tour to include Calgary, Banff, Lake Louise, Jasper State Park and Vancouver

September—*Spain and Portugal*

October 20—*Greek Isles Air/Sea Cruise:* a 14 day adventure to include Athens and a seven night cruise to Rhodes, Santorini, Mykonos, Delphi and the Corinth Canal.

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS and auxiliary members at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact the travel department at ISMS headquarters.

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsiblity for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

Case Reports

Gastric CA Masquerading as Benign Ulcer In A 27-Year Old Patient

By Dorthe Rauholt, M.D., Roger A. Nosal, M.D., Ph.D., Edward J. DelBeccaro, M.D. and Anjum Hameeduddin, M.D./Chicago

Only 16 reported cases of gastric carcinoma have occurred in patients under age 30 since 1960. We report a case of a 27-year-old woman with gastric carcinoma who initially presented with signs and symptoms of recurrent gastric ulcer. Work-up for carcinoma by repeat X-ray, gastroscopy and multiple biopsy was essentially negative. Twelve months after initial presentation, repeat biopsy revealed adenocarcinoma of the stomach.

A 27-year-old woman was hospitalized with dizziness, weakness and coffee-ground emesis. Symptoms consistent with acute ulcer had been present for less than two weeks. She was transfused to replace blood loss. X-rays of the stomach and endoscopy revealed a benign-appearing gastric ulcer in the posterior wall of the lesser curvature of the fundus. The patient was treated conservatively. Ultrasound demonstrated cholelithiasis and cholecystectomy was performed. At that time abdominal viscera appeared grossly normal. She was discharged on antacids and a bland diet.

The patient experienced mild intermittent epigastric pain occasionally radiating to the back. Three months after discharge this increased in severity and was associated with nausea and bright red emesis. Cimetidine was added to the regimen and symptoms abated. Five months later, she skipped her daily cimetidine dose and developed severe epigastric pain, nausea and vomiting. During hospitalization, stomach X-rays and endoscopy demonstrated a 1.5cm ulcer in the same site as previously observed. The ulcer was described as benign in appearance and having firm margins. Seven biopsy specimens obtained from the rim showed features of ulceration and chronic inflammation. The same therapeutic regimen was continued after discharge and she did well clinically.

Twelve months following onset of original symptoms, during follow-up outpatient gastroendoscopy, the ulcer was described as having a deep crater with clean white exudate at the base. The walls were swollen, soft and friable. Four biopsies from the ulcer rim revealed adenocarcinoma.

The patient was hospitalized for metastatic work-up and possible laparotomy. During the 12 months since onset of ulcer symptoms she had lost 20 pounds. She was thin, but physical examination was otherwise normal. Laboratory studies included normal hemogram, WBC count of 10,500/cu mm with 72 polymorphocytes, 19 lymphocytes, 4 monocytes and 5 eosinophils. Blood type was B negative and CEA was

two. Electrolytes, SMA-12, liver function, renal function, liver-spleen nucleotide scan and chest X-ray were normal. The ulcer crater in the lesser curvature of the gastric fundus was unchanged radiographically. During laparotomy the stomach was described as generally soft except for wall nodularity at the ulcer site. Hard lymph nodes were found along the superior border of the pancreas. Liver metastases and a periaortic mass were present. Specimens were taken from these sites. In the absence of obstruction or bleeding and presence of extensive metastases, no additional procedures were performed. Stat frozen and subsequent paraffin sections revealed poorly differentiated adenocarcinoma of the stomach with metastases to liver and periaortic nodes.

Oncologic consultation was obtained and a chemotherapeutic regimen with 5-fluorouracil, adriamycin and mitromycin C was recommended. The patient denied her disease and was lost to follow-up, returning to her birthplace in Poland.

Discussion

Hansen and Hanson[1] reviewed the literature concerning gastric carcinoma in patients under 30 years of age finding only 15 reported since 1960. Incidence in women was at least equal to or even more frequent than in men. Seven of the cases reviewed by Hansen and Hanson involved lesions of the lesser curvature. An additional case report[2] was located and involved a 26-year-old male who three years after diagnosis and treatment for gastric ulcer was found to have adenocarcinoma. This case and ours were strikingly similar. Each had histories, initial X-ray and endoscopic studies consistent with benign lesser curvature ulcer disease and evidence only of inflammation on biopsy. Both responded at least temporarily to ulcer management and, after adenocarcinoma was demonstrated, were inoperable with extensive metastases.

It is well known that the prognosis of gastric carcinoma in patients under 30 is extremely dismal[1] and certainly any hope for a more favorable outcome requires earlier diagnosis. In the case presented here, several initial biopsies taken from the ulcer rim were benign but when repeated four months later, revealed adenocarcinoma. Assuming that adenocarcinoma was present from the onset of symptoms, X-ray and endoscopy with multiple rim biopsies failed to uncover underlying disease. Cytologic diagnosis from gastric washings have been shown to be complimentary to X-ray studies with accuracy rates of 94.5%.[3,4] Target biopsy of the rim and slough of malignant ulcerative lesions is diagnostic in 90% of cases.[5] Combined target biopsy and cytologic brushing improves diagnostic yield.[6] If with adequate medical therapy, significant healing of an apparently benign gastric ulcer fails to occur within six weeks, the possibility of underlying adenocarcinoma must be considered.[2] Such cases should be pursued actively with follow-up radiographs, selective endoscopic cell washings, target biopsy and surgery if necessary. Until complete healing of the lesion is demonstrated or malignancy diagnosed, the physician cannot be comfortable with a diagnosis of "benign" gastric ulcer in this or any age group. ◀

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EKG

(Continued from page 87)

Answers: 1. A, B, C 2. D

The twelve lead ECG shows sinus rhythm at a rate of approximately 100 beats per minute. The axis is rightward at +160°. The QRS has a normal duration. Right ventricular hypertrophy is diagnosed by the voltage in lead AVR. The main force of the vector of right ventricular hypertrophy is posterior and rightward. The P wave is tall in lead II and lead V_1 for a diagnosis of right atrial enlargement. There is no voltage for left ventricular hypertrophy. The location of the heart murmur with a normally but widely split second sound, a diminished P_2, a large pulmonary artery segment with normal or decreased pulmonary vascularity on chest X-ray, and the ECG all suggest pulmonic stenosis. Both the atrial and ventricular septal defects would increase pulmonary blood flow and vascularity. Tetralogy of Fallot has a normal pulmonary artery segment on chest X-ray and a single second sound. Mitral regurgitation has a systolic apical murmur. Our patient agreed to have a pulmonary artery catheter in place. The pulmonary artery pressure was 40/15mmHg while the right ventricle was 150/8mmHg. There was no evidence of left to right shunts. The pneumonitis was caused by diplococci or pneumococci and intravenous penicillin was ordered. The patient was complicated because of the presence of severe pulmonic stenosis and low blood flow to the lungs. She had a prolonged course in the hospital. ◀

BRIEF SUMMARY
PROCARDIA® CAPSULES For Oral Use
(nifedipine)

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NOC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

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PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks, taking fewer nitroglycerin tablets, doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



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(NIFEDIPINE) *Capsules 10 mg*

Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Doctor's News

PHYSICIANS IN THE NEWS—**Warren N. Barr, M.D.,** Elmwood Park, has been elected an honorary member of the Illinois Masonic Medical Center Board of Trustees.

Jack D. Clemis, M.D., Wilmette, has been elected to the board of governors, American Academy of Otolaryngology, Head and Neck Surgery.

Glen L. Ricca, M.D., Streator, was recently named a diplomate of the American Board of Family Practice.

Harold N. Walgren, M.D., J. D., Hinsdale, has been promoted to colonel and awarded the U.S. Air Force aeronautical rating of chief flight surgeon. Dr. Walgren, a radiologist and an attorney, serves with the Illinois Air National Guard based in Peoria.

PAST MEDICAL SOCIETY OFFICER WINS SPECIAL AWARD—Casper M. Epsteen, M.D., D.D.S., Chicago, was recently presented with the American Society of Maxillofacial Surgeons (ASMS) Special Achievement Award.

An active ISMS member and leader, Dr. Epsteen served as second vice-president in 1966-67. A past president of the Chicago Medical Society (1962-63) Dr. Epsteen was given the award for his outstanding contributions to maxillofacial surgery. A clinical professor of maxillofacial and plastic surgery at the Chicago Medical School, he has been senior attending surgeon for 25 of his 50 years at Michael Reese Hospital and Medical Center.

MEDICAL HISTORY BOOK—MEDICAL CARE IN PIONEER ILLINOIS, by John K. Crellin, describes settlers' battles with ill health and physicians' roles in health care from Illinois' statehood in 1818 to the end of that century.

MEDICAL CARE IN PIONEER ILLINOIS is the third book in the Southern Illinois University Medical Humanities Series. The ISMS Educational and Scientific Foundation contributed funds for the book's publication.

The author's narrative interweaves a pioneer history with a description of physicians' trials and tribulations during settlement along waterways in central and southern Illinois.

To purchase MEDICAL CARE IN PIONEER ILLINOIS send a check for $15.95 made payable to Southern Illinois University Foundation to: The Pearson Museum, Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708.

BONE MARROW TRANSPLANT PROGRAM—Rush Presbyterian-St. Luke's Medical Center, Chicago, now offers a new bone marrow transplant program. Patients are being accepted for allogeneic transplants for acute leukemia, chronic granulocytic leukemia, myelofibrosis, aplastic anemia, immunodeficiency disorders and selected other diseases. Clinical investigations will be conducted using cyclosporin as an immunosuppressant to prevent graft-versus-host disease.

Call or write: Dr. Solomon Adler (312) 942-3577 or Dr. William Knospe (312) 942-5982, Rush-Presbyterian-St. Luke's Medical Center, 1753 West Congress Parkway, Chicago, Illinois 60612.

RESOLUTIONS DEADLINE—The ISMS House of Delegates' annual meeting will convene Friday through Sunday, April 22-24, at the Chicago Palmer House hotel. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 23, 1983. Those received after that date will be considered late resolutions and require special action for possible consideration.

In accord with House policy, resolutions will be published in the *Journal* by author and subject only. Resolutions which were received in the ISMS offices by an earlier deadline, February 18, will be published in the March *IMJ.*

CME CONFERENCE ON MEDICAL CONSEQUENCES OF NUCLEAR WAR—A conference for physicians and other health care professionals on the medical consequences of nuclear war will be held at the University of Illinois at Urbana-Champaign, 1:00 to 4:30 p.m. Thursday, March 10. The conference will focus on the Illinois health care system.

For further information contact: Continuing Education and Public Service in the Health Professions, 371 Medical Sciences Building, 506 South Mathews, Urbana, Illinois 61801 or call (217) 333-8145.

HYPERTENSION DRUG STUDY—Northwestern University Medical School is seeking people with mild to moderate high blood pressure to participate in a study to test the effectiveness of two widely prescribed anti-hypertensive medications.

Participants must be taking no medication for high blood pressure or be able to discontinue their medication for at least five weeks. All tests and treatment required for the study will be free of charge. Transportation costs to the clinic, 303 E. Chicago Ave., will be reimbursed. For more information call (312) 649-8013.

CLINICAL PATHOLOGY TELECONFERENCES—The Spring, 1983, American Society of Clinical Pathologists Conferences will be offered at noon on the second Friday of each month, February through June. Topic areas include: laboratory identification of common organisms (Part I and II), immunohematology, autoimmune diseases, therapeutic drug monitoring, platelet function and testing, microbiology, acute leukemias, muscle pathology, clinical chemistry, problems in hemostasis, and cytopathology of the uterine cervix.

In addition, teleconferences in anatomic pathology will be held and include: histopathology of infectious diseases, clinical and surgical pathology of hyperparathyroidism, legal ramifications of heart disease, inflammatory non-neoplastic dermatoses and inflammatory diseases of the thyroid.

Each program qualifies for CME credit. ASCP teleconference participating locations will receive a set of 35mm transparencies or overheads and 10 copies of all printed materials.

For more information on ASCP teleconferences contact: Michael Kelleher, Customer Services Department, American Society of Clinical Pathologists, 2100 West Harrison St., Chicago, Illinois 60612 or telephone (312) 738-4857.

AMA COST EFFECTIVENESS BULLETIN—Medical societies, physicians and other health care professionals are invited to submit information on cost effective programs and activities for publication in the AMA's Cost Effectiveness Bulletin. The bulletin is designed to provide a communications network among state medical associations, county medical societies and national specialty societies. To share information on current programs with others send correspondence to: Leanne P. Irish, Department of Health Care Financing and Organization, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610 or call (312) 751-7044.

PRELIMINARY 1983 RESIDENT MATCH DATA—The Council on Medical Specialty Societies has published preliminary data from the National Resident Matching Program (NRMP). The NRMP figures show approximately 24,000 applicants for 18,500 available PGY1 positions in the 1983 match. There are about 1,500 PGY1 positions available outside the match, making the total first year positions available 20,000 for the 24,000 applicants.

ALLERGIC AND IMMUNOLOGIC DISEASE DOCUMENT—The American Academy of Allergy and Immunology (AAAI) and the National Institute of Allergy and Infectious Disease will provide third and fourth year medical students in the United States and Canada with complimentary issues of the *Primer on Allergic and Immunologic Diseases.* The *Primer* can be purchased for $10.00 through the AAAI, 611 East Wells Street, Milwaukee, Wisconsin 53202.

NEW NIMH PROGRAM—The National Institute of Mental Health has inaugurated a new intramural research program in which severely depressed patients, referred by physicians, can receive comprehensive diagnostic workups. A recent HHS news release states that psychiatric centers which offer biological evaluations may not have the capability of performing a workup as comprehensive as the NIMH intramural program. According to program coordinator Dr. David Pickar, they will evaluate clinical usefulness of at least eight biological tests for hormonal, neurotransmitter or receptor alterations associated with major affective disorders. The program will seek to determine the extent to which biological changes are specific to depression.

Qualifying patients will stay less than two weeks at the NIMH Clinical Center in Bethesda, MD, in an NIMH clinical research unit, to undergo tests. The test results will be released to the patients' doctors. There is no charge to the patients.

The biological tests for depression measure either: (1) amine neurotransmitters, (2) neuroendocrine hormones, or (3) cell membrane markers or receptors.

Physicians interested in referring patients to the NMIH program should contact Dr. Alec Roy at (301) 496-6295.

CLINICAL NUTRITION SCHOLARSHIPS—Third and fourth year medical students who have completed their required clerkships are eligible to apply for scholarships in clinical nutrition offered by the American Medical Association Education and Research Foundation.

The scholarship program consists of four-to six-week clerkships in general, pediatric, and surgical nutrition offered by 21 medical schools throughout the country. Scholarships are available for students in schools which do not have clinical nutrition clerkships available or do not offer a clerkship in their specialty. Students accepted to the program will receive $700 to defray living and traveling costs. Application deadline is August 1 for clerkships from December 1983 to June 1984. For application forms contact: Department of Foods and Nutrition, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call (312) 751-6514.

LITERATURE SERVICE—The American College of Cardiology (ACC) Griffith Resource Library has available a monthly literature service highlighting references to 19 separate areas related to cardiovascular disease. According to a recent ACC News Release, the service is designed to guide practitioners and researchers to the latest information on selected topics as quickly as possible after publication. The monthly service utilizes the National Library of Medicine's MEDLARS database.

Each month, subscribers receive a list of references covering 20-70 titles on subject areas such as angina, catheterization, coronary artery disease, exercise testing, hypertension, nuclear cardiology, pharmacology, reviews of diagnostic and treatment topics and more. The literature also provides in-depth access to ongoing research and experience. Abstracts will be included when available.

Cost for one topic (12 mailings) is $75 annually; additional topics are $60. Costs for foreign subscribers is $100 annually; additional topics are $85.

For more information contact the Griffith Resource Library, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 or call (301) 897-5400.

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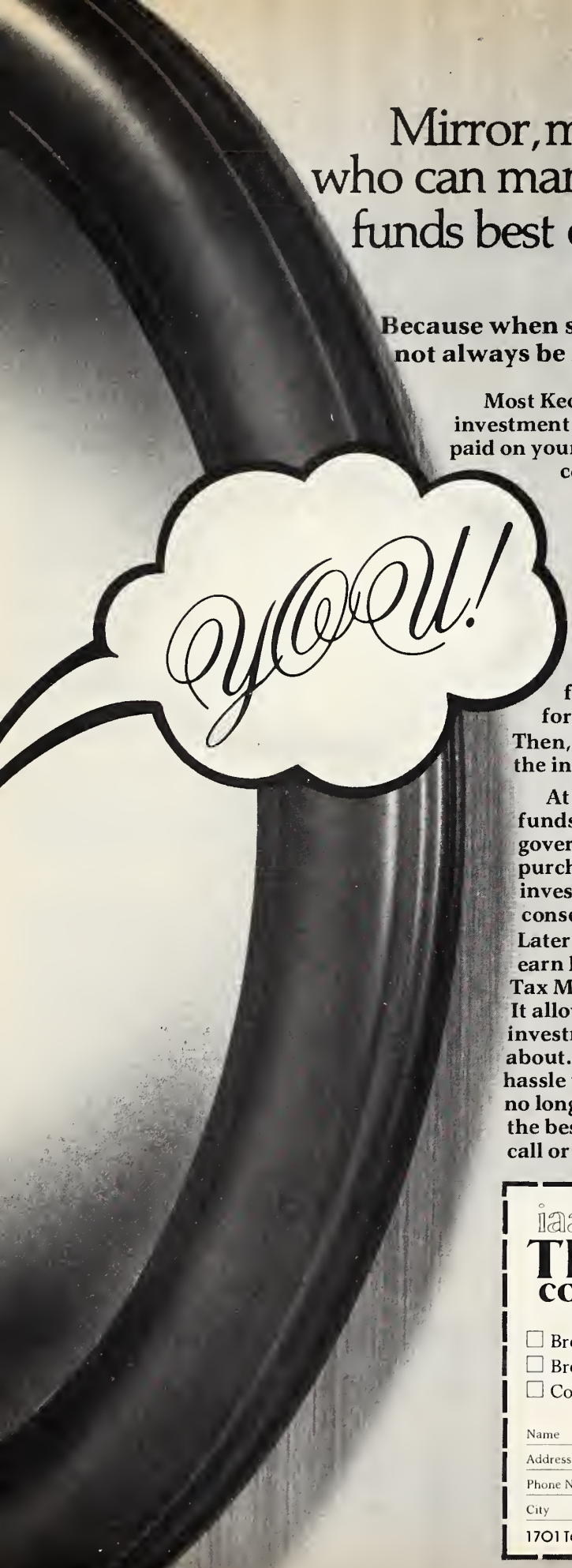
The IMPAC Scoreboard

	Congress	Statewide Offices	General Assembly	Total
Wins	10	6	138	154
Total Races With IMPAC Involvement	13	6	165	184

More than $200,000 in contributions and services for these candidates was dispersed by the IMPAC Council, and it was IMPAC's activity that made the difference in a number of close races.

IMPAC is now working on its 1984 game plan. We hope you will become a member of the IMPAC team.

Contributions ere not limited to the suggested emount Neither the Illinois Stete Medicel Society nor the AMA will fevor or disedventege enyone besed upon the emounts of or feiiure to meke pec contributions Contributions ere subject to the limitetions of FEC reguletions, Sections 110.1, 110.2, &110 5 (Federei Reguletions require this notice) IMPAC reports ere filed with the Stete Boerd of Elections, end ere or will be eveiieble for purchese from the Stete Boerd of Elections, 1020 South Spring Street, Springfield, Illinois, 62704 Voluntary membership contributions support politicel ection committee membership in IMPAC for cendidetes for public office in Illinois end cendidetes for federel office elsewhere through AMPAC.



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Because when somebody else does it, your funds may not always be invested where you want them.

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Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MARCH

Arthritis

Stote of the Art
For: MD's. Lecture, March 16, 12:30 p.m., Hyatt House, Oak Brook. **Sponsor:** DuPage County Medical Society, 800 Roosevelt Rd., Bldg. 8, Rm. 300, Glen Ellyn 60137. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Lilliam Widmer. **Phone:** 312-858-9603.

Cordiology

Coronory Diseose: Evoluotion & Treotment
For: MD's. Symposium, March 23, 6:00 p.m., Wood River. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Cordiology

Clinicol Monogement of Coronory Diseose
For: FP's, GP's, Internists. Seminar, March 25-27, McCormick Inn, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. **Reg. deodline:** none. **Fee:** $260. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800-525-8651 x 123.

General Interest

Medicol Consequences of Nucleor Wor
For: MD's. Lecture, March 10, 1:00 p.m., Urbana. **Speoker:** Herbert L. Abrams, MD. **Sponsor:** U of I College of Medicine, CME, 190 Medical Sciences Bldg., 506 S. Mathews, Urbana 61801. **Reg. deodline:** none. **Fee:** $30. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Linda Swett. **Phone:** 217-333-8145.

Internal Medicine

Loke County Medicol/Surgicol Seminor
For: Internists, Surgeons. Seminar, March 23, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Speoker:** Gerald Bodey, MD. **Fee:** $5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Dr. Adelman. **Phone:** 312-578-2555.

Internol Medicine

Stote & Notionol Board Review, Basic
For: MD's. Lecture, March 21 (6½ days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago. **Speoker:** Henry Jeffay, Ph.D. **Fee:** $450. **Reg. limit:** 90. **Credit:** Category 1, 62 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Internal Medicine

Stote & Notionol Boord Review, Clinicol
For: MD's. Lecture, March 28 (6 days) Chicago. **Speoker:** Henry Jeffay, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Category 1, 56 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Medical Educotion

Evoluotion of Clinicol Competence
For: MD's. Symposium, March 14-16, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Medicine

Stroke Symposium
For: MD's. Symposium, March 10-11, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Medicine

Basic Mechonisms & Clinicol Monogement of Shock
For: MD's. Symposium, March 3, 1:00-5:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Dysfunctionol Uterine Bleeding ond Evoluotion ond Treotment of Infertility
For: MD's. Symposium, March 10, 1:00-5:00 p.m., Pickneyville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 5 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Updote on Arthritis
For: MD's. Symposium, March 10, 3:00-8:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Use ond Abuse of Antibiotics
For: MD's. Symposium, March 31, 1:00-5:00 p.m., Flora. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Ophtholmology

Current Concepts Seminor
For: Ophthalmologists. Symposium/workshops, March 10-11, The Concourse Hotel, Madison, WI. **Fee:** T8A. **Reg. limit:** none. **Credit:** T8A. **Sponsor:** U of Wisconsin—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. : **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Ophthalmology

Loser Therapy of Glaucoma
For: Ophthalmologists. Symposium/workshop, March 10-11, Chicago. **Speoker:** Franz Fankhauser. **Sponsor:** Dept. of Ophthalmology, U of I College of Medicine, 912 S. Wood St., 2nd floor north, Chicago 60612. **Reg. deodline:** 2/24. **Fee:** $225, symposium; $475, symposium & workshops. **Credit:** Category 1, 7 hours, symposium; 6 hours, workshops. **Contact:** Sue Korienek. **Phone:** 312-996-8025.

Pediotrics

Pediotric Critical Core Symposium
For: Pediatricians. Symposium, March 2-3, Sheraton West Hotel, Indianapolis, IN. **Sponsor:** Indiana University, CME, 1604 N. Capitol Ave., Indianapolis, IN 46202. **Credit:** Category 1, 14 hours. **Contact:** Stephen Nugent, MD. **Phone:** 317-929-3733.

Plostic Surgery & Rodiology

Clinicol Applicotions of Advonced CT Technology for Monogement of Croniofociol Disorders
For: MD's. Symposium, March 19, St. Louis, MO. **Sponsor:** Washington University School of Medicine, CME, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. limit:** 150. **Credit:** Category 1, 7 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

Rheumotology

Proctical Monogement of Common Rheumotologic Disorders
For: MD's. Symposium, March 24-25, St. Louis, MO. **Sponsor:** Washington University School of Medicine, CME, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $200. **Reg. limit:** 150. **Credit:** Category 1, 13½ hours; AAFP Prescribed, 13½ hours, AOA, 13½ hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

Sports Medicine

Sports Medicine
For: MD's. Symposium, March 19, 8:00 a.m., Conrad Hilton Hotel, Chicago. **Speaker:** H. Bates Noble, MD. **Sponsors:** Illinois State Medical Society; Chicago Medical Society. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Chicago Medical Society Midwest Clinical Conference. **Phone:** 312-670-2550.

Workers' Compensotion Rehobilitotion & Neurology

Evoluation ond Treotment of Poin ond Disobility
For: MD's. Symposium, March 18, 1:00 p.m., Conrad Hilton Hotel, Chicago. **Speaker:** Eugene Rogers, MD, FACP. **Sponsors:** Illinois State Medical Society; Chicago Medical Society; Chicago Society of Physical Medicine & Rehabilitation. **Reg. deodline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Chicago Medical Society, Midwest Clinical Conference. **Phone:** 312-670-2550.

American Cancer Society
National Conference—
Breast Cancer
May 19-21, 1983
Boston Sheraton Hotel

Program participants will enhance their ability to recognize the high risk patient, select the most effective diagnostic procedure and understand the psychosocial needs of the patient; current concepts concerning the etiology and pathology of breast cancer will also be presented.

For further information:

Breast Cancer Conference
American Cancer Society
777 Third Avenue
New York, New York 10017
212-371-2900

APRIL

Cardiology

Post Myocardial Infarction Management
For: MD's. Symposium, April 8, 1:00 p.m., Taylorville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Gynecology

Current Management of Problems in Gynecology
For: Gynecologists. Course, April 22-23, Ritz Carlton Hotel, Chicago. **Sponsor:** Dept. of OB/GYN, U of Chicago, CME, 950 E. 59th St., Chicago 60637. **Fee:** $195; $100, residents. **Credit:** Category 1, 9 hours; ACOG, 9 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Medicine

Gastrointestinal Problems
For: MD's. Symposium, April 19, 7:00 p.m., Vondolio. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Neuraradialagy

Neuroradiology Review Course
For: General Radiologists, Neuroradiologists, Neurosurgeons. Course, April 30-May 1, Morriott Hotel, Oak Brook. **Sponsor:** Loyola University Center CME, 2160 S. First Ave., Maywood 60153. **Fee:** $140; $80, residents. **Credit:** Category 1, 15 hours. **Contact:** Lindo Gunzburger, PhD. **Phone:** 312-531-3237.

OB/GYN

Immunology of Reproduction
For: MD's. Lecture, April 22, 8:00 o.m., Chicago. **Sponsor:** UHS/CMS. **Cosponsor:** Cook County Hospitol, 1825 W. Harrison St., Division of Gynecologic Oncology, Chicago 60612. **Reg. deadline:** 2/15. **Reg. limit:** none. **Credit:** Category 1, 8 hours. **Contact:** Ben Blivoiss, PhD. **Phone:** 312-578-3215.

OB/GYN

Symposium on Obstetrics & Gynecology
For: MD's. Symposium, April 7-8, St. Louis, MO. **Sponsor:** Washington University School of Medicine, CME, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $200. **Reg. limit:** 150. **Credit:** Category 1, 13½ hours; AAFP Prescribed, 13½ hours; AOA, 13½ hours; 13½ cognotes. **Contact:** Loretto Giocoletto. **Phone:** 314-367-9673.

Office Management

Office Management and Computers
For: MD's. Symposium, April 7, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Pathalagy

Liver and GI Clinico-Pathologic Conference
For: MD's. Lecture, April 26, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Boy Road, North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312-578-3215.

Pathalagy

Specialty Review in Pathology/Anatomic
For: Pathologists. Lecture, April 11 (6 days), Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $425. **Reg. limit:** 90. **Credit:** Category 1, 48 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Pathalagy

Specialty Review in Pathology, Clinical
For: Pathologists. Lecture, April 18 (5 days), Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 90. **Credit:** Category 1, 41 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Pathology

Hemotopathology, Leukemias & Leukemoid Reactions
For: Pathologists. Lecture, April 11, 7:30 p.m., Droke Hotel, Chicago. **Speaker:** J. Vordimon, MD. **Sponsor:** Chicago Pathology Society, c/o Morshall Short, MD, Loretto Hospitol, 645 S. Central Ave., Chicago 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312-626-4300 x 383.

Pediatrics

New Frontiers in Developmental Pediatrics
For: Pediatricions. Symposium, April 27-28, Hilton Inn of Oak Lown. **Sponsor:** Christ Hospitol, 4440 W. 95th St., Oak Lown 60453. **Reg. deadline:** 4/12. **Fee:** $100. **Credit:** Category 1, 10 hours. **Contact:** Cheryl Ehrhort. **Phone:** 312-857-5682.

Pulmanary Diseases

Pulmonary Diseases Symposium
For: MD's. Symposium, April 28, 1:00 p.m., Jocksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Radialagy

Radiology Update
For: MD's. Symposium, April 13, 6:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Radialagy

Specialty Review in Radiology
For: Radiologists. Lecture, April 25 (5 days), Chicago. **Speaker:** Rogelio Moncado, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Rheumatalogy

Rheumatology
For: MD's. Symposium, April 30, 1:00 p.m., Mt. Carmel. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Uralagy

Specialty Review in Urology
For: Urologists. Lecture, April 25, (5½ days), Chicago. **Speaker:** Thomas John, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 200. **Credit:** Category 1, 53 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Utilization Review

Third Party Payers
For: MD's. Lecture, April 17, Morriott Hotel, Oak Brook. **Sponsor:** Illinois Regional Chapter of Americon College of Utilizotion Review Physicions, c/o 1108 N. Second Street, Horrisburg, PA 17102. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 5 hours. **Contact:** Betty Hommon. **Phone:** 717-697-442B.

MAY

Back Pain

Back Pain Conference
For: MD's. Conference, May 13-14, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** TBD. **Reg. limit:** none. **Credit:** TBD. **Contact:** Sarah Aslokson. **Phone:** 608-263-2856.

Cardialagy

Treatment of Acute Myocardial Infarction
For: MD's. Symposium, May 18, 6:00 p.m., Highland. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Cardiac Rehabilitation

Cardiac Rehabilitation Symposium
For: MD's. Symposium, May 4-6, Milwoukee, WI. **Sponsor:** U of WI—Extension, CME, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $250, MD; $155, other. **Reg. limit:** none. **Credit:** T8D. **Contact:** Soroh Aslokson. **Phone:** 608-263-2B56.

Dermatalagy

Dermabrasion, Chemical Peel, Silicone, Collagen
For: Dermatologists. Workshops/lectures, May 18-21, Chicago. **Sponsors:** The American Society for Dermatologic Surgery; Northwestern University, 303 E. Chicago Ave., Chicago 60611. **Fee:** none. **Reg. limit:** 100. **Credit:** Category 1. **Contact:** Henry Roenigk, Jr., MD. **Phone:** 312-649-8173.

Medicine

Gastroenterology
For: MD's. Symposium, May 26, 1:00 p.m., Jocksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Medicine

Dermatologic Therapeutics in General Practice
For: MD's. Symposium, May 17, 7:00 p.m., Effinghom. **Fee:** $40. **Reg. limit:** none. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 3 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Pathology

Non-Hodgkin's Lymphoma
For: MD's. Lecture, May 9, 7:00 p.m., Chicago. **Speaker:** R. J. Hortsock, MD. **Sponsor:** Chicago Pathology Society, c/o Morshall Short, MD, Loretto Hospitol, 645 S. Central Ave., Chicago 60644. **Reg. deadline:** 4/29. **Fee:** dinner only. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312-626-4300.

Pediatrics

Pediatrics
For: MD's. Symposium, May 25, 1:00 p.m. Nashville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

Surgery

The Management of Burn Patients Today
For: MD's. Symposium, May 26, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield, 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorroine Stephenson. **Phone:** 217-782-7711.

AMA VIDEO CLINICS

The AMA has recently annaunced faur additians ta its Video Clinic Library:

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Special Articles

ISMS Sponsors Educational Programs At CMS Midwest Clinical Conference

The ISMS sports medicine, workers compensation and loss prevention education committees will be conducting educational programs at the Chicago Medical Society's Midwest Clinical Conference. The Board of Trustees offers such programs in the interest of providing educational programs which will improve the practice of medicine.

Sports Medicine

H. Bates Noble, M.D., sports medicine committee chairman, will coordinate a program featuring current sports medicine issues on Saturday, March 19, at 8:00 a.m. Topics and speakers include: "Practical Rehabilitation of Athletic Injuries" by Robert Hamilton, M.D., "Use of Ergogenic Aids in Athletics," by Jacob R. Suker, M.D. and "Nutrition in Athletics" by Richard B. Parr, Ed.D.

Evaluation and Treatment of Pain and Disability

Eugene Rogers, M.D., F.A.C.P., workers' compensation committee chairman, will coordinate a program which highlights rehabilitation and current workers' compensation medical issues on Friday, March 18, at 1:00 p.m. Topics and speakers include: "Workers' Compensation—Physician Roles and Responsibilities," by Georgianne Riley, legal counsel, Industrial Commission of Illinois, "Neurological Evaluation and Treatment of Pain Syndromes," by E. Richard Blonsky, M.D., "Rehabilitation Evaluation Care in Disability" by Eugene Rogers, M.D. and "The Role of Vocational Guidance in Pain and Disability" by Raymond Sakalas, M.D. This program is planned in cooperation with the Chicago Society of Physical Medicine and Rehabilitation.

Malpractice/Loss Prevention Education Program

The ISMS loss prevention education committee, in conjunction with the Illinois Council on Continuing Medical Education, will present a special program dealing with common concerns of malpractice liability of physicians and practical ways in which physicians can help reduce the possibility of a malpractice suit.

The program will take place on Sunday, March 20, from 8:30 a.m. to 12:30 p.m. Highlighting the program will be presentations by attorneys John Langhenry and Gary Peplow on legal issues and court proceedings which apply to medical malpractice. Practical case discussions will be moderated by Alfred J. Clementi, M.D., Donal D. O'Sullivan, M.D., J. D., and the two attorneys. Also featured will be Richard A. Ott, CAE, ISMS staff, who will discuss the importance of interpersonal communications in reducing the possibility of malpractice suits.

All programs will earn participants four hours of Category 1, CME credit and are suitable for physicians with medical specialties which directly utilize program information or physicians with general interest in the issues to be presented.

The Chicago Medical Society's Midwest Clinical Conference is conducted at the Conrad Hilton Hotel, March 18-20, 1983. Registration materials and information on program offerings is available by contacting the Chicago Medical Society, Division of Professional and Community Education, 515 North Dearborn, Chicago, IL, 60610 (telephone 312/670-2550).

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CLASSIFIED ADVERTISING RATES

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	$6.00	$9.00	$14.00	$20.00
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12 insertions	33.00	44.00	77.00	110.00

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FAMILY PRACTITIONER, licensed in Illinois, board eligible/certified, American trained, to join established group in busy near north side, modern office. Please send curriculum vitae to: Box #1068 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

FAMILY PRACTITIONER—To locate in Rosiclare, Illinois. 53-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forrest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare, IL. 62982. (618) 285-6634.

PRIMARY CARE PHYSICIAN (family practice, internal medicine, pediatrics, general surgery) board certified or eligible. Small, rural hospital located in Southern Illinois, 25 minutes from Southern Illinois University School of Medicine, which is presently building new patient care areas, has need for minimum of 3 primary care physicians. Hospital space available soon for office suites. Extremely attractive package offered to those interested in establishing and building a solo or group practice. Please submit your resume as soon as possible to: E. A. Helfrich, Union County Hospital, 517 N. Main, Anna, IL 62906.

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PRACTICE WANTED—American Internist—Gastorenterologist interested in quality practice in internal medicine, or gastroenterology or internal medicine-gastroenterology in Chicago, western, northwestern or northern suburbs. Will share, rent or purchase. Write to Box #1067 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

PODIATRIST Wishes to affiliate with medical group. Seeks practice opportunity or salaried position. Interested in surgery, general practice and sports medicine. Chicago or suburbs contact Box #1066 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

FAMILY PRACTITIONER, Illinois licensed, American born & trained, relocating to Chicago/North-Northwest Suburbs. Seeks full time association with group (family practice or multispecialty) involved in quality private, HMO or industrial practice. Write to Box #152, 606 W. Barry, Chicago, Ill., 60657.

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President's Page



VALE

My tenure as your spokesman on medical affairs is now drawing to a conclusion. It has been a great honor to have served as president of the Illinois State Medical Society, but an even greater personal satisfaction has been the opportunity to meet so many fine physicians throughout our state. To all those who have made and continue to make contributions to organized medicine, often at considerable sacrifice of their personal and professional time, I offer my sincere thanks. Our noble profession would not be in the forefront in dealing with the many problems that confront medicine today without your tireless and unselfish efforts. ◀

C. C. Wiggishoff M.D.

Cyril C. Wiggishoff, M.D., President

The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,
Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Carl E. Johnson, M.D., department of radiology, Loyola University Medical Center, Maywood.

A 22 year old man whose radiographs are shown below had pain and swelling in his right hand approximately 4 months ago. He received antibiotics to treat a presumed soft tissue infection with resolution of his symptoms. He has had back pain and erythema, pain, and swelling of his left knee for several weeks. In addition to this, his hand is again edematous and painful. He has no systemic symptoms.



Figure 1
AP view of thoraco-lumbar spine.



Figure 2
AP view of left knee.

What is your diagnosis?

1. Leukemia
2. Lymphoma
3. Tuberculosis
4. Coccidiomycosis
5. Metastatic seminoma

(Continued on page 217)



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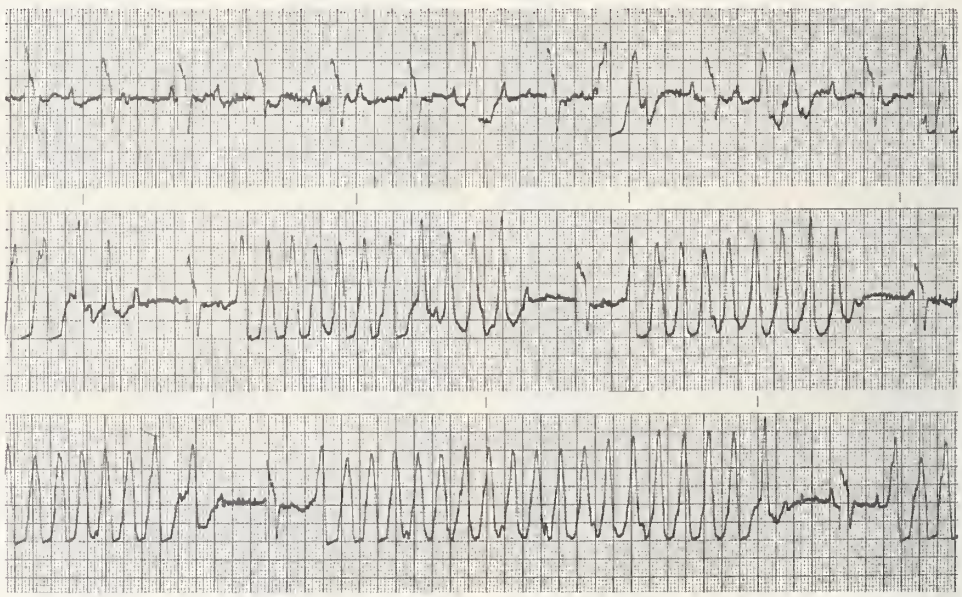
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EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a forty-eight year old woman with a previous history of congestive cardiomyopathy of unknown etiology. She had bouts of congestive heart failure complicated by pulmonary hypertension and cardiac arrhythmias. Her cardiac arrhythmias were so difficult to manage that a programmable demand pacemaker had been implanted six months earlier. She now complains of intermittent near-syncope and one syncopal episode. There was no incontinence or post-ictal state associated with her syncope. Examination of the lungs showed mild crepitant rales in both bases. Cardiac exam demonstrated a left parasternal lift with an increased pulmonic component of the second sound. There was an occasional premature beat. She was admitted to an ECG monitored bed. A chest X-ray showed moderate cardiomegaly and prominent pulmonary vasculature. In the hospital she had a syncopal episode. This ECG rhythm strip occurred shortly after resuscitation.



Questions

1. **The ECG rhythm strip shows:**
   a. Atrioventricular dissociation.
   b. Paroxysmal ventricular flutter.
   c. Cycle dependent bundle branch block.
   d. A well functioning demand pacemaker at 72 beats per minute.
   e. Electrode artifact.

2. **The following statement(s) is/are true:**
   a. Syncope can be caused by a tachyarrhythmia.
   b. Syncope can be caused by a lack of appropriate increase in cardiac output, as in primary pulmonary hypertension.
   c. Ventricular tachyarrhythmias occur commonly in the late stages of primary pulmonary hypertension.
   d. Symptoms in pulmonary hypertension are probably all the result of low cardiac output and hypoxemia.
   e. All of the above.

(Continued on page 212)

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Population 7,000, County—17,000. Hospital looking to recruit three physicians for primary care solo and/or group practice. Twenty-Five miles from Carbondale and the SIU-Medical School. Financial assistance negotiable. Hospital office suites available soon for physicians' practice. Contact: Ken Simpson, 517 N. Main, Anna 62906 618-833-5155. (5)

DANVILLE: Family Physicians desiring independent practice near a larger community with two hospitals and wanting the security of start-up support with guarantees. Call N. L. Saxton, M.D. (217) 443-5204 or send curriculum vitae to 812 North Logan Avenue, Danville, 61832. (4)

GENEVA: SMALL TOWN MEDICINE/BIG CITY ADVANTAGES—Seeking physician to join board certified active family practice group. Thriving community of 10,000, west of Chicago. Modern, well equipped, 3 physician office with full lab and x-ray facilities. 110 bed primary care hospital 1 mile from office. Salary guarantee, malpratice coverage, other benefits. Opportunity for full partnership. Send resume and C.V. to: P.O. Box 72, Geneva, Illinois 60134. (3)

GIBSON CITY: Cardiologist, Internist wanted to join expanding multi-specialty medical staff associated with modern well equipped hospital; ICU capable of invasive monitoring; attached privately funded SNF; new professional office space available; rural community in east central Illinois within 30 minutes of major universities, tertiary care centers, metropolitan areas with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City, 60936 (217/784-4251). (7)

GLEN ELLYN: Physicians wanted to staff urgent care and industrial medicine facility in private practice in western suburbs of Chicago. Hourly base plus incentive package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, S. C., 454 Pennsylvania Ave., Glen Ellyn 60137. 312-469-9200. (5)

GLEN ELLYN: Physicians wanted—internist and family physician to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. CONTACT: Dave Bauer, Adm., Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave., Glen Ellyn 60137 (312-469-9200). (5)

GRIGGSVILLE: North Pike County in immediate need of family practitioner. Practice partnership opportunity with established FP. Remodeled clinic, six months' free rent with supplies and basic equipment. 78-bed hospital with OB and C/CCU, pathologist and radiologist on site. Service area of 19,000 with 3 surgeons and 7 GPs (5 FAAFP). Medical student preceptorships on site and within one hour of family practice residency. One hour from Quincy, 1½ hours from Springfield, 2 hours from St. Louis. Excellent recreational facilities nearby. Contact Ronald Johnson, MD, FAAFP, 121 N. Franklin, Pittsfield 62363 (217-734-2386) or Cheryl Bielema, 110 N. Union, Griggsville 62340 (217-833-2665). (3)

LA HARPE:—Population 1200. Seeking replacement for one of two Family Physicians in community. 64 bed hospital including 49 long term; affiliation with nearby regional medical center; office facilities and financial assistance available. Educational/recreational facilities—Mississippi River nearby. Contact: Richard Miller, Administrator, La Harpe Hospital, La Harpe 61450, 217/659-3011. (3)

ROSICLARE: FAMILY PRACTITIONER/INTERNAL MEDICINE—53-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare 62982. (618) 285-6634. (3)

SAYBROOK: Family practitioner—Excellent opportunity in East Central Illinois; large modern office available due to recent physician retirement; rural setting near modern well equipped community hospital; also within twenty minutes of major university tertiary care center, metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact: William Stack, Saybrook 61770. (309) 475-3521. (5)

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BRIEF SUMMARY
PROCARDIA® CAPSULES For Oral Use
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INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks, taking fewer nitroglycerin tablets, doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

[*] Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

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TABLETS

ANACIN-3® (III)

ACETAMINOPHEN

with Codeine 15 mg, 30 mg, 60 mg

Each tablet contains acetaminophen and codeine phosphate* as follows:
acetaminophen, 325 mg and codeine phosphate*, 15 mg (¼ gr)
acetaminophen, 300 mg and codeine phosphate*, 30 mg (½ gr)
acetaminophen, 300 mg and codeine phosphate*, 60 mg (1 gr)
*WARNING: May be habit forming.

Please see adjacent page for brief summary of prescribing information.

TABLETS
ANACIN-3 (III)
ACETAMINOPHEN
with Codeine 15mg, 30mg, 60mg

Brief Summary ***(For full prescribing information see package insert.)***
Description: Each Tablet Contains.
Acetaminophen 325 mg, and Codeine Phosphate*, 15 mg
Acetaminophen 300 mg, and Codeine Phosphate*, 30 mg
Acetaminophen 300 mg, and Codeine Phosphate*, 60 mg
*WARNING: May be habit forming
Contraindications: Hypersensitivity to acetaminophen or codeine.
Warnings: Drug Dependence: Codeine can produce drug dependence of the morphine type, and may be abused. Dependence and tolerance may develop upon repeated administration. Prescribe and administer with the same degree of caution appropriate to the use of other oral narcotic medications. Subject to the Federal Controlled Substances Act (Schedule III).
Precautions: *Head injury and increased intracranial pressure.* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal conditions. Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.
Special risk patients: Administer with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Information for Patients: Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly.
Drug-Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety, or other CNS depressants (including alcohol) concomitantly with acetaminophen and codeine may exhibit additive CNS depression due to the codeine component. When such therapy is contemplated, the dose of one or both agents should be reduced.
The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.
The concurrent use of anticholinergics with codeine may produce paralytic ileus.
Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.
Nursing Mothers: It is not known whether the components of this drug are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when acetaminophen and codeine are administered to a nursing woman.
Adverse Reactions: Most frequently: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting. More prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Others: Euphoria, dysphoria, constipation and pruritus.
Dosage and Administration: Dosage should be adjusted according to severity of pain and response of the patient. However, it should be kept in mind that tolerance to codeine can develop with continued use and that the incidence of untoward effects is dose related. This product is inappropriate even in high doses for severe or intractable pain. Adult doses of codeine higher than 60 mg fail to give commensurate relief of pain but merely prolong analgesia and are associated with an appreciably increased incidence of undesirable side effects. Equivalently high doses in children would have similar effects.
Adults: **Codeine**—15-30 mg (for mild to moderate pain)
60 mg (for moderate to moderately severe pain)
Acetaminophen—300-600 mg
Children: **Codeine**—500 mcg/kg
Doses can be repeated up to every 4 hours.
Full directions for use should be consulted prior to administering or prescribing.

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Anacin-3 ☆ Codeine 30 mg
Sig: ii q 4 h prn
Disp: #28

Obituaries

****Addenbrook, Edward F.,** Tucson, Arizona, died January 5, 1983 at the age of 83. Dr. Addenbrook was a 1925 graduate of Northwestern University Medical School, Chicago.

****Fox, Edward F.,** Laguana Hills, California, died January 1, 1983 at the age of 93. Dr. Fox was a 1911 graduate of the University of Illinois College of Medicine.

****Hodges, Harry D.,** Palos Heights, died January 9, 1983 at the age of 77. Dr. Hodges was a 1932 graduate of the University of Tennessee College of Medicine, Memphis.

****Ijams, Russell Lynn,** Atlanta, died December 15, 1982 at the age of 81. Dr. Ijams was a 1931 graduate of Northwestern University Medical School, Chicago.

***McCready, Robert B.,** Chicago, died December 28, 1982 at the age of 68. Dr. McCready was a 1940 graduate of the Loyola University Stritch School of Medicine, Maywood.

***McElroy, Robert E.,** Elmhurst, died December 22, 1982 at the age of 58. Dr. McElroy was a 1951 graduate of the University of Illinois College of Medicine, Chicago.

***Movius, Alfred H.,** Houston, Texas, died December 24, 1982 at the age of 74. Dr. Movius was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

***Neustadt, Jerome E.,** Chicago, died December 26, 1982 at the age of 53. Dr. Neustadt was a 1953 graduate of Indiana University School of Medicine, Indianapolis.

***Noble, Thomas A.,** Homewood, died January 10, 1983 at the age of 67. Dr. Noble was a 1940 graduate of Northwestern University Medical School, Chicago.

****Schneidewind, Oswald G.,** New Athens, died October 13, 1982 at the age of 78. Dr. Schneidewind was a 1928 graduate of Washington University, School of Medicine, St. Louis.

****Traub, Anthony B.,** Miami Shores, Florida, died January 10, 1983 at the age of 81. Dr. Traub was a 1928 graduate of the Loyola University Stritch School of Medicine, Maywood.

**Indicates ISMS member*
***Indicates member of the Fifty Year Club*

Pulse of the ISMS Auxiliary

Are You Aware . . .

Stress

By Diane Hinderliter/ISMSA President

Hans Selye[1] described stress as the nonspecific response of the body to any demand made upon it. Another study defined stress as the need to adapt to changing life events. The theoretical basis for this approach to stress research is the General Adaption Syndrome described by Selye.[2] The three stages of stress that exist, according to Selye, are the alarm reaction, resistance, and exhaustion. These stages are the body's attempt to restore equilibrium or adapt to the situation causing the stress. Holmes and Rahe[3] developed a weighted scale of life events that required adaption and attached weighted scores to the various events. The cumulative score obtained is considered a measurement of stress and is indicative of the risk for physical and emotional illness.

Stress has also been studied in relation to occupations. Fuller[4] found that 50% of the cases reported by industrial physicians could be attributed to occupational stress. Selye[5] estimated that 9-15% of the health services utilized by middle and upper management levels were related to occupational stress. Weiman[6] discovered that occupational stress can result in stroke, heart attack, and death.

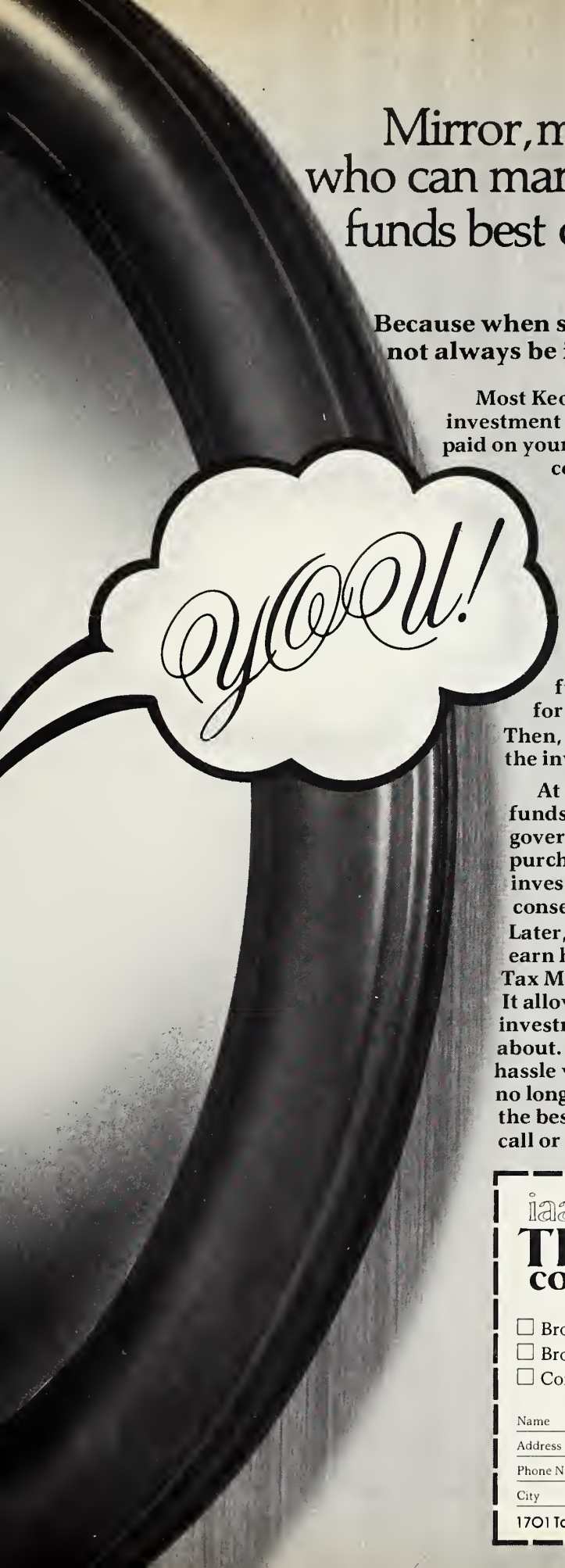
Stress is everywhere in our daily lives, but it need not be detrimental. Stress keeps us alert, protects us from dangers, and calls us to action. It is when the stress is prolonged at a high level that it can result in illness or disease.

The physician's family life can be very stressful due to schedule, time constraints, demands on the physician's time, emergencies, etc. Our children see how we handle stress and they, in turn, will probably handle it much the same way. One of the first things we can do, as physicians' spouses, to begin to deal with stress, is to know ourselves a little better. Self assessment is the first step to mastery over our lives. No one ever said the world was fair. When we begin to make an issue over something, we might try asking ourselves if five years from now it will really make a difference. Don't spend a lot of time worrying about what people think. Karioth[7] states that while acceptance or rejection by strangers can't be an indicator for our behavior that lesson is often one of the hardest to assimulate when carving out self worth. Many times we expect others to totally meet our needs. If all of our gratification must come from external forces, sooner or later we will find that our needs aren't being met. With no internal satisfaction our lives can become very empty. This can really cause stress in the family. If we spend our lives waiting for someone to reinforce us we will always be waiting. We must learn to cultivate and develop enough internal dignity and self worth so that we can reinforce ourselves and not be left to the mercy of others.

As mothers and spouses we can do a great deal every day to keep stress at a healthy level in our households. If we can recognize that we are no different from anyone else in the world, then we can allow ourselves to develop and grow. If we can laugh at ourselves, our children will learn to do this also. If we can shrug things off that don't really matter and concentrate on the important issues of the family, our children will probably be able to do the same. The most important thing we can do is like ourselves and be happy where we are. If we are happy, chances are, our children will also be. Remembering that there can be no rainbows without the rain will do much to alleviate stressful situations within the family. ◀

References

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4. Fuller, G.: Biofeedback: Methods And Procedures, San Francisco: Biofeedback Press, 1977.
5. Selye, H.: "Stress In Daily Life," paper presented at the Biofeedback Society of America Conference, 1978.
6. Weiman, C.G.: "A Study of Occupational Stressors and the Incidence of Disease/Risk." *Journal of Occupational Medicine,* 19:2. 1977.
7. Karioth, S.: "Since the World Revolves Around You, Why Aren't You In Charge?" *Imprint,* 28:28, 1981.



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Abstracts of Action

January 29, 1983 — *Palmer House, Chicago, Illinois*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

HOSPITAL MEDICAL STAFFS

The Board heard a report on the need to develop resources for county medical society use in developing liaison with local hospital medical staffs. A pilot program will be developed. County societies will be encouraged to develop formal linkages with hospital staffs.

Related to this, the Board appointed an Ad Hoc Committee of Dr. Robert Johnson, Chairman, Dr. Warren Tuttle, ex-officio, and Drs. Jerry Ingalls, John Ring, Alfred Clementi, Robert Hamilton and Cyril Wiggishoff, to address the issue of physicians on hospital medical staffs and the AMA Section on Hospital Medical Staffs as it relates to ISMS and the county medical societies.

1983 BUDGET AND FINANCIAL MATTERS

After thorough review of program and zero-based budgeting considerations, the Finance Committee developed a surplus budget which was examined by the Executive Committee. The budget fully meets the Society's program needs, and realistically reflects current required activities since a surplus for both 1981 and 1982 was realized, and with a budgeted 1983 surplus, there should be sufficient reserve to meet program needs until 1985. Capturing actual costs incurred for each activity has allowed reimbursement for shared services staffing activities.

Acting on the Executive Committee report, the Board:

- Adopted the 1983 budget reflecting a $233,545 surplus, with expenses of $4,579,883 and revenue of $4,813,428; and also allocated part of the 1982 projected undesignated surplus to permanent reserves.
- Cancelled the 1983 Washington Roundup and agreed not to include funding in the 1983 budget.
- Authorized the ISMS Educational & Scientific Foundation to contribute $7,500 for the renovation of the Transparent Anatomical Manikin exhibit at the Museum of Science and Industry; and that the AMA be asked to contribute a matching amount.
- Approved the November 30, 1982 Financial Statements and accepted the January 13, 1983 Voluntary IMPAC Report and December 31, 1982 and January 13, 1983 Membership Dues Collection Report, and approved changes in membership status.
- Renewed the Directors and Officers Liability Insurance through International Insurance Company at a three year premium of $70,483.
- Heard a report that the Benevolence Fund currently has expenses of $62,000 a year and income of $47,000 a year. The difference has been met by Auxiliary contributions. The Board requested the Finance Committee to evaluate the Fund's purpose relative to future goals.

(Continued on page 222)

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INDERAL, a logical first step

Unlike thiazide diuretics, which can provoke serious reductions of serum potassium, INDERAL has been found to maintain or modestly increase serum potassium levels.[1,2] Therefore, the consequences of hypokalemia—including the threat of ventricular arrhythmias[2]—may be significantly reduced.

INDERAL acts to reduce catecholamine-induced "spiking" of blood pressure which often coincides with the physical and emotional stress in a hypertensive's life.[3] INDERAL reduces elevated heart rate, force of ventricular contraction, and cardiac work load—providing smooth control of hypertension to decrease the risk of related cardiovascular complications. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.)

INDERAL works in a way that non-beta blockers can't—to provide long-term cardiovascular benefits.

INDERAL provides treatment for coexisting angina pectoris or cardiac arrhythmias in addition to reducing blood pressure—for comprehensive protection. What's more, INDERAL is well tolerated, acting with few of the distressing side effects of antihypertensive agents such as methyldopa or reserpine. Impotence, depression, sedation, orthostatic hypotension, and nasal stuffiness are rare. (Please see following page for Brief Summary of Prescribing Information, including side effects of INDERAL.)

Indeed, INDERAL has changed the face of antihypertensive therapy, worldwide. And it continues to do so—with an unparalleled record of clinical efficacy and experience.

INDERAL. It's the kind of protection hypertensive patients need—right from the start.

References: 1. Traub, Y. M., *et al.*: Clin. Pharmacol. Ther. *28*:765 (Dec.) 1980. 2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. *647* (Suppl.):67, 1981. 3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

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B.I.D. FOR HYPERTENSION

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
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Inderal® (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time, can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

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Editorial

The Ultimate Decision

By Cyril C. Wiggishoff, M.D.
ISMS President

For the past two decades, politicians of every persuasion have promised the public an ever increasing number and variety of benefits affecting every facet of what has come to be regarded as the "good life." One important public expectation that has been fostered is that everyone is entitled to unlimited medical care, irrespective of its cost. Fortunately, during this same period, economic circumstances in the United States have permitted this promise to be honored for the most part.

With the escalation of health care costs [now amounting to just under ten percent of the gross national product] and the decline of the United States' economy, unlimited medical care to all who seek it is no longer affordable. As a result, some very difficult choices need to be addressed. Some services may have to be restricted or even discontinued.

The important point that we physicians must keep in the forefront of our thinking is that we are, by our training and ethics, committed to provide sick people with whatever measures are necessary to make them well. While we have a duty to provide medical care in the most cost-effective manner possible, we are under no obligation whatever to decide which patient should be denied a service or whether any established medical service should be discontinued. We may, in the process of health planning, point out to the public what various services cost, or what may be the effects of depriving the public of a medical service. Ultimately, the decision to restrict medical services must be made by society . . . not by the medical profession. ◀

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Primary Adenocarcinoma Of the Appendix

By Joseph J. Casey, M.D., Thomas J. Snopek, M.D., Ph.D., David F. Rader, A.R.T. And James V. Apostol, M.D./Chicago

Three cases of primary adenocarcinoma arising in the vermiform appendix are described. Two presented with symptoms consistent with acute appendicitis or appendiceal abscess. One presented as a bowel obstruction secondary to intussusception. Two of the three patients had anemia and one of these had guaiac positive stools as the only suggestion of a malignant etiology. A review of the literature and an analysis of these cases confirms the recommendation that right hemicolectomy with node dissection is the appropriate treatment of primary adenocarcinoma of the appendix.

Primary adenocarcinoma of the appendix is a diagnosis seldom made preoperatively. Over one-half of the patients present with symptoms and signs consistent with acute appendicitis or appendiceal abscess.[1] The incidence of adenocarcinoma of resected appendices is reported to be approximately 0.082%. The incidence of carcinoids of the appendix is many times that of adenocarcinoma and is thought to vary from 0.3% to 0.7% of all surgically removed appendices.[2] The only clues which may suggest the true nature of the process are the presence of anemia or hemoccult positive stools. The following three cases represent experiences with primary adenocarcinoma of the appendix at two hospitals over a five year period.

JAMES V. APOSTOL, M.D., is a board certified surgeon affiliated with Northwestern Memorial Hospital in Chicago as well as the Veterans Administration Lakeside Hospital. A recipient of the James Ewing Society Resident Award, Dr. Apostol specializes in surgical oncology.

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THOMAS J. SNOPEK, M.D., Ph.D., is a resident physician in pathology at Northwestern Memorial Hospital, Chicago. Dr. Snopek's first doctorate was in biochemistry.

JOSEPH J. CASEY, M.D., is a resident physician in general surgery at Northwestern Memorial Hospital in Chicago.

Report of Cases

Case 1: A 58-year-old black man presented with a seven day history of anorexia, obstipation and continuous periumbilical pain. On the day before admission he administered an enema with satisfactory results but immediately developed right lower quadrant pain. Physical examination was unremarkable except for an obese abdomen. There was localized pain in the right lower quadrant. There was no rigidity or rebound. The rectal examination was reported as normal. Laboratory data showed Hct 49%, Hgb 16.0, WBC=15,100.

The patient was taken to the operating room with a preoperative diagnosis of acute appendicitis. A right lower quadrant muscle-splitting incision was made and an abscess cavity drained. Subsequent work-up included a barium enema which demonstrated a filling defect in the cecum. Three weeks later the patient underwent a laparotomy and right hemicolectomy. Examination of the specimen revealed a perforated carcinoma of the tip of the appendix. The tumor extended through the serosa at the site of perforation. Two lymph nodes were noted without pathologic di-



Figure 1

agnosis.

Postoperatively the patient received radiation therapy (4600 rads to the right lower quadrant) and chemotherapy with 5-fluorouracil. He did well for one year when he presented with a small bowel obstruction prompting exploration. At that time there was carcinomatosis of the abdominal cavity and a closed loop obstruction. A side-to-side proximal ileo-transverse colostomy was performed to restore continuity of the gastrointestinal tract while the closed loop was decompressed with a side-to-side ileo-descending colostomy. The patient did poorly postoperatively and died fifteen months after initial surgery.

Case 2: A 66-year-old black man presented with a ten day history of vague epigastric pain which eventually localized to the right lower quadrant. Physical examination was unremarkable except for a tender mass in the right lower quadrant of the abdomen. There was no rigidity or rebound. The rectal examination was normal and guaiac negative. Laboratory data revealed Hct 32.5, Hgb 11.5, with a normal WBC.

With a preoperative diagnosis of appendiceal abscess, the patient was taken to the operating room and explored through a right lower quadrant muscle-splitting incision. Distally the appendix



Figure 2

was edematous and adherent to the abdominal wall and appeared to be perforated at the base. The cecum appeared normal. The appendix was removed without difficulty. The wound was drained and the subcutaneous layer and skin left open. Histologic examination of the specimen revealed moderately well-differentiated adenocarcinoma involving the appendix and periappendiceal tissue consistent with primary appendiceal carcinoma. The patient was returned to the operating room two weeks later and a right hemicolectomy was performed. There was residual tumor in the cecum at the orifice of the appendix. Thirteen nodes were negative for tumor.

Over the next 18 months the patient did well, excepting three episodes of bowel obstruction which were managed conservatively with long-tube decompression. He died, however, from complications of small bowel obstruction. Autopsy revealed diffuse serosal metastatic implants.

Case 3: An 84-year-old black man was admitted with increasingly severe crampy mid-abdominal pain for two weeks. He also complained of anorexia and diarrhea which was often black. During the time of these symptoms, he lost 15 lbs. On physical examination there was a right upper quadrant tender mass which measured 8cmx15cm. No other abnormalities were noted. The rectal examination was unremarkable and guaiac negative. Laboratory data showed Hct 35.7, Hgb 12.2, WBC=4,000. A barium enema was performed, demonstrating an abrupt cut-off in the right upper quadrant with a convex filling defect consistent with intussusception. (Figure 1)

The patient was taken to the operating room where an intussusception was found with the appendix and terminal ileum intussuscepting into the ascending colon up to the hepatic flexure. (Figure 2) The appendix appeared tense and edematous. Attempts at reduction were aborted



Figure 3

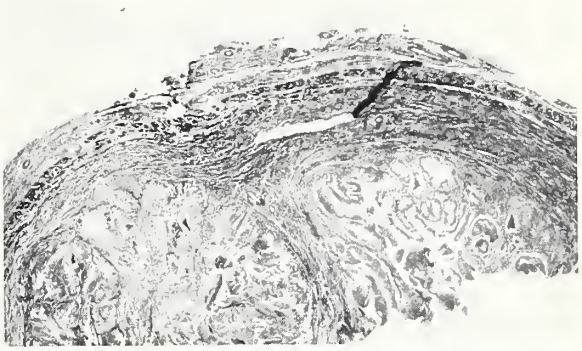


Figure 4

when the presence of a fibrinous exudate on the serosal surface raised the possibility of perforation. A right hemicolectomy was performed. Examination of the specimen demonstrated adenocarcinoma of the appendix at the junction of the cecum. (Figures 3 and 4) Three of the five regional lymph nodes were involved. The patient is alive and doing well at this writing.

Comments

In 1943, Uihlein and McDonald classified malignant epithelial neoplasms of the appendix into three types: (1) carcinomas of the carcinoid type, (2) carcinomas of the cystic type producing *pseudomyxoma peritonei* (malignant mucocele), and (3) carcinomas which resemble both grossly and microscopically those found in the colon (adenocarcinoma).[3] The latter two are histologic variants of the same tumor with the malignant mucocele being a better differentiated tumor. They continue to be classified separately, however, because of the different natural history and prognosis.

Histologically, appendiceal adenocarcinomas may be differentiated with well-formed glands or undifferentiated with signet ring cells. The tumor most frequently involves the base of the appendix (unlike carcinoid, which tends to be at the tip). Symptoms may be due to obstruction of the appendiceal lumen with distal inflammatory changes or, if there is ulceration of the tumor, this ulceration may lead to melena or occult blood in the stool.[3] Intussusception of an appendiceal tumor is unusual, although 19 such cases have been found in the literature. These tend to involve mucoceles rather than adenocarcinoma and in only three cases was the resulting mass large enough to be detected on physical examination.[3]

Appendiceal adenocarcinoma otherwise behaves like other colonic adenocarcinomas. They spread by local invasion, lymphatics and the blood stream. Since the muscular layers of the appendix are frequently incomplete or absent, direct extension to adjacent structures may occur early. Otto and his associates point out that submucosal invasion in the appendix is really subserosal extension. The lymphatic drainage of the appendix is the same as that of the terminal ileum and cecum.[6]

Whereas appendectomy may be adequate treatment for appendiceal carcinoid or malignant mucocele, a right hemicolectomy with node dissection is indicated in all cases of primary adenocarcinoma of the appendix. In 1963, Hesketh collected 50 patients with follow-up. Those patients undergoing appendectomy for appendiceal carcinoma had a five year survival rate of 20%. Those undergoing right hemicolectomy had a five year survival of 63%. In 1976, Anderson and his associates collected 51 patients with 46% (12/26) being alive five years after appendectomy alone. Sixty percent were alive after right hemicolectomy.[7] ◀

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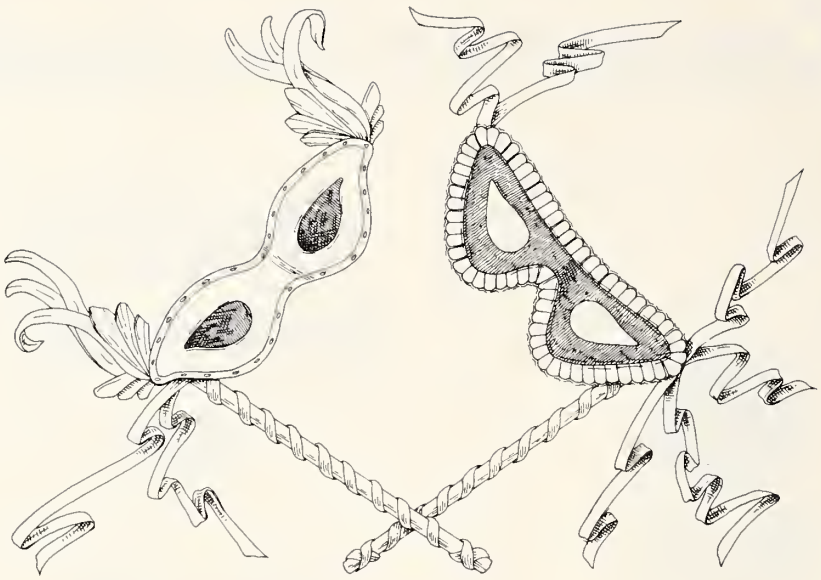
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Resident Physicians Section	David Whitney	Michael Nieder

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Delegates	*Alternate Delegates*	*Delegates*	*Alternate Delegates*
Aaronson, Donald	Ahstrom, James, Jr.	Murray, Meredith B.	Nosal, Roger
Andelman, Samuel L.	Banuchi, Fedor F.	Nemecek, Raymond W.	Nourbakhsh, M.
Andersen, James H.	Becker, Frank O.	Neskodny, J. F.	Olson, James C.
Armstrong, Claresa	Beinar, Peter J.	Odiaga-Garcia, Ignacio	Palmer, Arthur
Bartolome, Juanito	Bellows, Randall	O'Keefe, Paul	Panton, John H.
Beck, Charles A.	Borelli, Nelson	O'Sullivan, Donal D.	Pantone, Anton M.
Berg, Max	Burdick, Allison L., Jr.	Okner, Henry B.	Pardo, Yrech
Bogen, Gilbert	Burdick, Allison L., Sr.	Olen, Richard N.	Poma, Pedro A.
Bragman, Robert	Burke, Edward A.	Olivar, Adriano	Proffer, Dirk
Branovacki, Eugene	Chaljub, Najib	Pamintuan, Rodolfo L.	Pruc, Jeremias N.
Brislen, Andrew J.	Christensen, Eldis M.	Panayotou, Irene	Puczynzki, Mark S.
Burkhead, Howard C.	Cucco, Ulisse P.	Pedroso, Aldo	Renga, Dominick
Carroll, Catherine G.	Del Fava, Raymond L.	Perritt, Richard	Rezvan, A.
Ciskoski, Ronald J.	DeTrana, Frank E.	Peterson, Arthur R.	Richardson, James M.
Coleman, John M.	DiMarco, Eugene R.	Petty, David T.	Rodriguez, Alberto E.
Costanzo, Vincent A.	Elegant, Lawrence D.	Pill, Michael	Rodriguez, Ignacio
Cross, Roland R.	Elward, Kurtis	Quinlan, Donald	Roman, Alan M.
Czeisler, Tibor	Fabian, Sydney	Razim, Edward A.	Saltiel, Isaac
Danckers, Ulrich F.	Feldman, Sydney	Rice, C. Malcolm, Jr.	Saulys, Vacys
Diaz, AlFonso	Filipowicz, Roman I.	Romanus, Raymond J.	Schall, Samuel M.
Diffenbaugh, W. G.	Forgione, Hebe M.	Rothstein, David A.	Schwartz, Malcolm
Dohrmann, George	Fredrick, Earl E., Jr.	Ruzich, Stanley	Schwartz, Sheldon D.
Falloon, Edwin L.	Friedell, Peter E.	Schifano, Joseph	Seglin, Melvin N.
Farah, George S.	Gianasi, Charles	Schimel, Samuel J.	Senno, Aref
Fish, William	Gnade, Gerard R.	Schuetz, John N.	Siedentop, Karl H.
FitzGibbons, James P.	Gogan, William	Sedlak, Frank	Silverstein, Gerald E.
Flanagan, C. Larkin	Goodman, Harold	Seed, Randolph	Smith, William S.
Frankel, Jerome J.	Gorday, Rose L.	Short, Marshall	Sprang, Milton L.
Gertz, George	Gorny, Edward J.	Simon, Arnold	Stevenson, George
Green, Martin W.	Goyal, Arvind K.	Sinaiko, Edwin S.	Stockhammer, Dan
Guerrero, Severo K., Jr.	Graham, James	Smith, C. Otis	Strohl, Lee H.
Harrod, John	Graudins, Gunars	Soboroff, Burton J.	Study, Robert S.
Harwood, Thomas P.	Gueyikian, Berj	Solon, Earl N.	Sultan, Thomas R.
Hinkamp, Joseph F.	Handler, Jerome L.	Springer, Harry	Sutoris, Edward D.
Hoban, Eugene	Johnson, M. Anita	Staley, Warren H.	Talso, Peter J.
Hoeltgen, Maurice	Jones, Richard	Stephens, Natalie	Thampy, Kishore J.
Horton, Loren B.	Kawala, Karen	Suckow, Earl E.	Thomas, Andrew R.
Hughes, Joseph	Keer, Larry M.	Sugar, Sam J.	Tobin, John T.
Hutchison, William A.	Knudson, John A.	Swartz, Robert M.	Zitek, Russell W.
Hyde, John S.	Landau, Richard L.	Tansey, William J.	
Jensen, Harold	Lipsich, Michael	Tekdogan, Mehmet M.	
John, Thomas	Lucina, Pedro A.	Thompson, J. Robert	
Joslyn, A. Everett, Jr.	McCabe, Mary Joan	Tovar, Jorge	
Kahn, Sidney C.	McLennon, Peter	Triester, Michael R.	
Kalsch, Harry E.	Meccia, Donald	Uhrich, John H.	
Kaplan, Tammy	Meyenberg, John	Ungar, Jacob	
Kaz, Alex H.	Modi, C.M.	Vega, Jesus	
Kirschenbaum, M. Barry	Mostowfi, Kiumars	Walkowiak, Lydia	
Lagorio, George L.	Munoz, Maria	Wehrmacher, Wm. H.	
Libman, Robert H.	Muriel, Hugo H.	Williams, Jack	
Lobraico, Rocco V., Jr.	Mustell, Robert R.	Zurita, Victor	
Lukaszewski, Edwin J.	Neumann, Helen A.		
MacNerland, Robert H.	Nicholas, Everett E.		
Marshall, William	Nikurs, Lydia		

1983 Officers Of County Medical Societies

County	President	Secretary
Adams Members: 105-Dist 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	Walter Stevenson III 1101 Maine, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
Alexander Members: 10-Dist. 9	Gemo Wong 529 Cross, Cairo 62914	Gemo Wong 529 Cross, Cairo 62914
Bond Members: 9-Dist. 7	Thomas D. Dawdy 100 N. Locust, Greenville 62246	Boyd A. McCracken 100 N. Locust, Greenville 62246
Boone Members: 22-Dist. 12	Earl S. Davis 2170 Pearl St., Belvidere 61008	John Steinkamp 824 S. Van Buren, Belvidere 61008
Bureau Members: 40-Dist. 2	Merle Piacenti 600 E. 1st St., Spring Valley 61362	Swasdi Pothikamjorn 4040 Progress Blvd., Peru 61354
Carroll Members: 8-Dist. 12	Lemuel B. Hussey P.O. Box 99, Savanna 61074	Cecil G. Piper 203 W. Market St., Mt. Carroll 61053
Cass-Brown Members: 1-Dist. 6		
Champaign Members: 230-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	Lewis Trupin 301 E. Springfield, Champaign, 61820	Paul W. Yardy 602 W. University, Urbana 61801
Christian Members: 26-Dist. 7	Deogracias F. Quizon 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
Clark Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Eugene P. Johnson P. O. Box 68, Casey 62420
Clay Members: 7-Dist. 7	Donald L. Bunnell Flora Clinic, Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
Clinton Members: 12-Dist. 7	Jonathan V. Osborn PO Box 99, Breese 62230	James A. Kirby 401 N. Main, Breese 62230
Coles-Cumberland Members: 55-Dist. 8	Ronald D. Miller Link Clinic, Mattoon 61938	Donald E. Binz 1810 Charleston, Mattoon 61938
Cook Members: 8498-Dist. 3 Fred Schwartz, Exec. Dir. 515 N. Dearborn St. Chicago, IL 60610	Alfred J. Clementi 675 W. Central Road Arlington Hts., 60005	Richard H. Blankshain 715 Lake St., Oak Park 60301
Crawford Members: 11-Dist. 8	Frank Gross 1002 Allen, Robinson 62454	W. B. Schmidt Schmidt Clinic, Robinson 62454
DeKalb Members: 63-Dist. 12	Paul Stromborg 954 W. State St., Sycamore 60178	William F. Stach 407 W. State St., Sycamore 60178
DeWitt Members: 10-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas Members: 7-Dist. 8	Humberto Mondul 111 W. S. Central, Tuscola 61953	Grant A. Jones 318 S. Ash, Arthur 61911

County	President	Secretary
DuPage Members: 707-Dist. 11 Lillian Widmer, Ex. Sec. 800 Roosevelt Road Building B-Suite 300 Glen Ellyn 60137	W. P. Gibbons Good Samaritan Hosp., 38th & Highland, Downers Grove 60515	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham Members: 16-Dist. 7	Herbert F. Webb Marshall Clinic, Effingham 62401	Ruben Boyajian 606 W. Kentucky, Effingham 62401
Fayette Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth St., Vandalia 62471
Ford Members: 11-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
Franklin Members: 30-Dist. 9	Yihnan Chiou 502 W. St. Louis St., Frankfort 62896	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
Fulton Members: 40-Dist. 4	Jessie M. Reyes 210 W. Walnut, Canton 61520	Thomas C. Schrepfer 511 Promenade, Havana 62644
Gallatin Members: 2-Dist. 9		John E. Doyle Ridgway 62979
Greene Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
Hancock Members: 12-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson Members: 2-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	Silvino Lindo, Jr. Biggsville 61418
Henry-Stark Members: 36-Dist. 4	Luis Jose Garcia Kewanee Public Hosp., Kewanee 61443	Richard M. Terry 420 S. Chestnut, Kewanee 61443
Iroquois Members: 20-Dist. 11	Leslie Duis 845 S. 4th St., Watseka 60970	Steve Swedlund 125 S. 4th, Watseka 60970
Jackson Members: 113-Dist. 9	Punnoose Pachikara 106 S. 14th St., Murphysboro 62966	Brian G. McElveny 404 W. Main, Carbondale 62901
Jasper Members: 2-Dist. 8	Monico Low 609 S. Van Buren, Newton 62448	Juan J. Serra 507 W. Washington, Newton 62448
Jefferson-Hamilton Members: 37-Dist. 9	Charles Longwell, Jr. #1 Doctors Park, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
Jersey-Calhoun Members: 10-Dist. 6	Abbas Assar 122 E. Bridgeport, Whitehall 62092	Bernard Baalman Medical Center, Hardin 62047
Jo Daviess Members: 9-Dist. 12	David Hockman 219 Summit St., Galena 61036	Francis B. Waites 219 Summit St., Galena 61036
Kane Members: 320-Dist. 1 H. Michael Wild, Ex. Dir. 355 First St. Batavia 60510	Thomas Stemper 1870 W. Galena, Aurora 60506	Francis Oslay 1705 South St., Geneva IL 60134
Kankakee Members: 111-Dist. 11	Ray R. Schale 475 W. Merchant St., Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901

County	President	Secretary
Kendall Members: 8-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
Knox Members: 82-Dist. 4 Mrs. Jane Gau, Exec. Sec. Galesburg Cottage Hospital 695 N. Kellogg Galesburg 61401	Edward S. Peterka 612 Bondi Bldg., Galesburg 61401	Subbia G. Jagannathan 695 N. Kellogg, Galesburg 61401
Lake Members: 415-Dist. 1 Julia Schultz, Ex. Sec. P.O. Box 148 Gurnee 60031	J. Vickers Brown 1160 Park Ave. West, Highland Park 60035	Allan B. Minster 135 N. Greenleaf, Gurnee 60031
LaSalle Members: 102-Dist 2	Robert F. Bettaso 1703 Polaris Circle, Ottawa 61350	Allan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence Members: 13-Dist. 8 Ruth E. Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Alexander Po RR 4, Lawrenceville 62439	Francisco E. Martin 542 N. Main, Bridgeport 62417
Lee Members: 24-Dist. 12	Robert J. Piha 101 W. Mason, Polo 61064	Tiam H. Lie Rt. 5, Castellan, Dixon 61021
Livingston Members: 27-Dist. 2	Homer C. Parkhill 202 N. Main, Pontiac 61764	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
Logan Members: 25-Dist. 5	Steven D. Kottemann 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
Macon Members: 163-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Howard L. Wibbels 2300 N. Edward, Decatur 62526	H. Gale Zacheis 2220 N. Monroe, Decatur 62526
Macoupin Members: 19-Dist. 6	Dean Raft 217 W. Main St., Staunton 62088	Robert England 935 Morgan, Carlinville 62626
Madison Members: 208-Dist. 6	Thomas C. Hill #1 Lakewood IV, Edwardsville 62025	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion Members: 44-Dist. 7	Otto S. Espinosa 205 N. Davis St., Centralia 62801	W. P. Plassman Box 552, Centralia 62801
Marshall-Putnam Members: 3-Dist. 2	Donald M. Gallagher Box 538, Granville 61326	Joe W. Cannon, M.D., Secretary 202 South Main, Lacon 61540
Mason Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
Massac Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
McDonough Members: 30-Dist. 4	Wendell K. Stewart 301 E. Jefferson, Macomb 61455	Richard C. Watson 525 E. Grant, Macomb 61455
McHenry Members: 78-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Richard Gorski 715 W. Judd, Woodstock 60098	Daniel L. Vodovotz 1110 N. Green St., McHenry 60050

County	President	Secretary
McLean Members: 128-Dist. 5 Mrs. Madge Williams, Exec. Sec. 1236 E. Empire Bloomington 61701	Robert M. Reardon 1008 N. Main St., Bloomington 61701	John R. Krueger #1 Medical Hills Dr., Bloomington 61701
Mercer Members: 5-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	Dennis D. Palmer 409 NW Fourth, Aledo 61231
Monroe Members: 10-Dist. 10	Chung Khan 112 E. Fourth St., Waterloo 62298	Edilberto Maglasang 109 W. Legion, Columbia, 62236
Montgomery Members: 20-Dist. 5	Dennis Ross Billiter Med. Arts. Bldg., 1235 E. Union Litchfield 62056	Roger Wujek Medical Arts Building 1225 E. Union, Litchfield 62056
Morgan-Scott Members: 50-Dist. 6	Raymond E. Major 800 W. State, Jacksonville 62650	John Peterson 400 Farmers Bank Building, Jacksonville 62650
Moultrie Members: 4-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
Ogle Members: 16-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
Peoria Members: 419-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st National Bank Bldg. Peoria 61602	Lorin D. Wittaker, Jr. 214 N.E. Glen Oak, Peoria 61603	Thomas G. Cassidy 515 N.E. Glen Oak, Peoria 61603
Perry Members: 15-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
Piatt Members: 4-Dist. 7	George Green 1111 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike Members: 11-Dist. 6	B. J. Rodriguez 868 Mortimer, Barry 62312	Carlos B. Lara 326 W. Washington, Pittsfield 62363
Pulaski Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
Randolph Members: 20-Dist. 10	Orlan W. Pflasterer Coulterville 62237	J. M. Whittenberg 1650 State St., Chester 62233
Richland Members: 24-Dist. 8	Richard O. Peach 800 E. Locust, Olney 62450	Chandri Varadachari Richland Memorial Hosp., Olney 62450
Rock Island Members: 197-Dist. 4 James A. Koch, Ex. Sec. 608 Kahl Bldg. 326 W. Third St. Davenport, Iowa 52801	Ralph D. Ade 550 30th Ave., Moline 61265	Philip T. Siegert 1504 7th St., Moline 61265
St. Clair Members: 272-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main Belleville 62223	Michael G. Murphy 6401 W. Main, Belleville 62223	Harold S. Harsin 115 W. Randle, Lebanon 62254
Saline-Pope-Hardin Members: 32-Dist. 9	Albert G. Bledig 1405 Locust, Eldorado 62930	Allen G. Gerberding Prof. Arts Bldg., U.S. Rte. 45 South, Harrisburg 62946

County	President	Secretary
Sangamon Members: 402-Dist. 5 L. R. Brosi, Ex. Dir. 522 E. Monroe, Room 203 Springfield 62701	William W. Curtis 100 W. Miller St., Springfield 62702	Elvin G. Zook SIU School of Medicine, PO Box 3926, Springfield 62708
Schuyler Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby Members: 9-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson Members: 57-Dist. 12	Ahmed Rasheed 1036 W. Stephenson, Freeport 61032	Richard L. Rice 750 Kiwanis Dr., Freeport 61032
Tazewell Members: 75-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Wayne M. Keiserman PO Box 778, Pekin 61554	Terry O. Tosi P.O. Box 778, Pekin 61554
Union Members: 12-Dist. 9	Thomas W. Davis 319 S. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Main St., Anna 62906
Vermilion Members: 113-Dist. 8	Brijnandan F. Sodhi 735 N. Logan, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
Wabash Members: 5-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren Members: 14-Dist. 4	James W. Marshall 319 N. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington Members: 6-Dist. 10	Methee Vanadilok 111 S. Washington, Nashville 62263	Gary A. Goforth 113 W. St. Louis, Nashville 62263
Wayne Members: 9-Dist. 9	Sigmund W. Konarski 101 E. Center Rd., Fairfield 62837	Eugene B. Loftin 301 N.W. Eleventh St., Fairfield 62837
White Members: 8-Dist. 9	Phillip D. Boren Doctors Clinic, Carmi 62821	P. G. Ravindranathan Doctors Clinic, Carmi 62821
Whiteside Members: 53-Dist. 12	Shashi A. Patel 1601 First Ave., Sterling 61081	Thomas E. Vinje 101 E. Miller Rd., Sterling 61081
Will-Grundy Members: 254-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Leo A. Wrona 2415 W. Jefferson, Joliet 60435	Theodore Dastych Joliet Medical Group, 2100 Glenwood, Joliet 60435
Williamson Members: 38-Dist. 9	Timoteo Castro 120 W. Walnut, Herrin 62959	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago Members: 399-Dist. 12 Robert Carlson Exec. Adm. 630 E. Jefferson Rockford 61107	Robert H. Harner 3271 Montlake Dr., Rockford 61107	Jovenel Dubois 5670 E. State St., Rockford 61108
Woodford Members: 7-Dist. 2	Victor V. Jay 601 N. Jefferson, Washburn 61570	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society: Edwards, Johnson, Menard

Joint County Societies: Cass-Brown; Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will-Grundy.

Agenda

1983 House of Delegates

Clifton L. Reeder, M.D., *Speaker*

Julian W. Buser, M.D. *Vice-Speaker*

FIRST SESSION

9:30 a.m.—Friday, April 22, 1983
Palmer House
Chicago

1. Call to order
   Clifton L. Reeder, M.D., *Speaker*
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Approval of minutes of previous meeting
6. Memorial Service for members deceased since April, 1982 conducted by Jere Freidheim, M.D., *Secretary-Treasurer*
7. Introduction of Special Guests
8. Report of Chairman, Board of Trustees
   Warren D. Tuttle, M.D.
9. Remarks of Speaker
10. Resolutions and supplementary reports
11. New business and announcements

    Reference Committees—1:30 p.m.
    Delegates' Buffet—11:30 a.m.-1:30 p.m.
12. Recess until 9:30 a.m., Saturday, April 23, 1983

SECOND SESSION

9:30 a.m.—Saturday, April 23, 1983
Palmer House
Chicago

1. Call to order by the Speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Reports of special guests
   Mrs. Diane Hinderliter, *President,* Illinois State Medical Society Auxiliary
   Janet Binkowski, R.N., *President,* Illinois Society, American Association of Medical Assistants
5. Introduction of special guests
   Remarks—AMA Representative
6. Presentation of certificates of appreciation to Continuing Medical Education Examiners
7. Presentation of AMA-ERF check to Illinois medical schools
8. IMPAC Report
   Paul Mahon, M.D., *Chairman*
9. Report of Executive Administrator
   Mr. Alexander R. Lerner
10. Introduction of AMA Delegates and Alternate Delegates
    Howard C. Burkhead, M.D., *Chairman*
11. President's Address
    Cyril C. Wiggishoff, M.D.
12. New business and announcements
13. Reports of Reference Committees
14. Recess until 2:00 p.m.
15. Call to order by the speaker
16. Reports of Reference Committees

    Amendments to Constitution and Bylaws

    Committee A—Officers, Administration, Finances and Budgets
    Committee B—Government Health Programs, including National Health Insurance and Cost Containment
    Committee C—Education, Manpower and Clinical Medicine
    Committee D—Medical Service and Economic Matters Outside of Government Programs
    Committee E—Governmental Affairs and Medical Legal
    Committee F—Public Relations, Membership and Miscellaneous Business
17. New Business
18. Recess until 9:00 a.m.—Sunday, April 24, 1983

THIRD SESSION
9:00 a.m.—Sunday, April 24, 1983
Palmer House
Chicago

1. Call to order by the Speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Remarks—Gov. James R. Thompson
5. Induction of Robert P. Johnson, M.D., President-Elect, into office of President by Cyril C. Wiggishoff, M.D.
6. Address of President Johnson
7. Announcements and introduction of guests
8. Reports of reference committees
9. Elections

   Report of Nominating Committee

   (a) President-Elect (CMS)
   (b) 1st Vice President (DS)
   (c) 2nd Vice President (CMS)
   (d) Secretary-Treasurer
   (e) Speaker of the House (DS)
   (f) Vice Speaker (CMS)
   (g) Trustee Terms Expiring

District	*Terms Expiring*
Second District	Allan L. Goslin, M.D.
Third District	Audley F. Connor, M.D.
Third District	Robert C. Hamilton, M.D.
Third District	Harold J. Lasky, M.D.
Third District	Richard N. Rovner, M.D.
Third District	Joseph C. Sherrick, M.D.
Eleventh District	Kenneth A. Hurst, M.D.
Twelfth District	Joseph B. Perez, M.D.

   (h) Delegates to AMA to take office January 1, 1984 and serve until December 31, 1985

Terms Expiring

Herschel Browns, M.D., Chicago
Howard Burkhead, M.D., Evanston
Jack Gibbs, M.D., Canton
Theodore Grevas, M.D., Rock Island
Morgan M. Meyer, M.D., Lombard
Maynard I. Shapiro, M.D., Chicago
Joseph Skom, M.D., Chicago
Cyril C. Wiggishoff, M.D., Chicago

   (i) Election of 17th Delegate to AMA to take office immediately and serve until December 31, 1984
   (j) Alternate Delegates to AMA to take office January 1, 1984, and serve until December 31, 1985

Terms Expiring

Alfred Clementi, M.D., Arlington Heights
Allan Goslin, M.D., Streator
Robert C. Hamilton, M.D., Chicago
A. Beaumont Johnson, M.D., Elgin
Harold Lasky, M.D., Chicago
Michael Nieder, M.D., Chicago
Arthur Traugott, M.D., Urbana
Ronald Welch, M.D., Belleville
Fred Z. White, M.D., Chillicothe

   (k) Election of 17th Alternate Delegate to AMA to take office immediately and serve until December 31, 1984
   (l) Judicial Panel to take office April 24, 1983 and serve until April 1988

   Frank Norbury, M.D., Jacksonville, nominated by ISMS President

   (m) Rules and Order of Business to take office April, 1983 and serve until April, 1984

   Five (5) Delegates nominated by the Speaker of the House

10. Fixing of per capita dues for 1984
11. Selection of meeting place and time for next meeting
12. Unfinished business
13. New business
14. Adjournment, Sine Die

Resolutions 1983 Annual Meeting ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 18 and, according to provisions of the bylaws, are printed in *IMJ* by title and subject. Final deadline for resolutions was March 23. At this writing, it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

Number	*Subject*	*Submitted by*
1 (A-83)	Amendment to Chapter IV., Section 4 of the ISMS Bylaws	Robert P. Johnson, M.D., for the Board of Trustees
2 (A-83)	State Tax Credits or Deductions in Lieu of Reimbursement for Care of Public Aid Recipients	Alfred J. Clementi, M.D., Chairman, Cook County Delegation

Committees of the House of Delegates
1983 Annual Meeting

COMMITTEE ON RULES & ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (30 days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

REFERENCE COMMITTEE A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances and budgets.

REFERENCE COMMITTEE B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including national health insurance and cost containment.

REFERENCE COMMITTEE C

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower and clinical medicine.

REFERENCE COMMITTEE D

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical service and economic matters outside government programs.

REFERENCE COMMITTEE E

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to governmental affairs and medical legal matters.

REFERENCE COMMITTEE F

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations, membership and miscellaneous business.

Report to the House of Delegates

Illinois Delegation To The American Medical Association

The Interim Session of the AMA House of Delegates was held December 5-8, 1982. Illinois was represented with 16 delegates on the floor at all times the House was in session.

Four resolutions were introduced from Illinois. Item, subject matter and action are as follows:

Resolution 47: *"Use of the Term Physician,"* was reviewed by the Reference Committee and a Substitute Resolution adopted, re-affirming a previous definition from 1972. It was pointed out that the Federal regulations which would have broadened the definition of physician had been withdrawn.

Resolution 48: *"National Library of Medicine,"* was referred to the Board of Trustees for further study.

Resolution 49: *"Health Care Coalitions,"* was reviewed in depth. A Substitute Resolution was adopted. The Substitute Resolution met the intent of the Illinois Resolution in that it called for strong participation by physicians in any coalition, with primary emphasis given to the quality, availability and access to medical care.

Resolution 50: *"AMA Section for Hospital Medical Staffs,"* was probably among the most controversial items addressed at this session. In keeping with ISMS House action, there was strong opposition to establishing still another section, and strong testimony was provided in Reference Committee and on the floor of the House. Those opposed to creating this new Section were in the minority and thus a new Section has been established. During the course of the meeting bylaws amendments were adopted to allow seating for representatives of this Section at the next session.

Dr. Ring has entered his name as a candidate for the AMA Board of Trustees. The Delegation unanimously supports him in this endeavor. It will be a difficult race and the assistance of all ISMS members is encouraged.

We also have been informed that Dr. Gibbs will not be a candidate for re-election to the Council on Medical Education. Dr. Gibbs has served Illinois and the AMA well over a long period of time and it is with regret that we accept his decision to withdraw from service on the Council.

During the course of the meetings of the Delegation, a new Chairman and Secretary were elected. The Chairman is Dr. Howard Burkhead of Evanston and the Secretary is Dr. Morgan Meyer of Lombard.

ISMS DELEGATION TO THE AMA

Delegation Chairman: Howard C. Burkhead; Secretary: Morgan Meyer

Delegates

To serve from Jan. 1, 1982 to Dec. 31, 1983

(Elected April 7, 1981)

Herschel Browns, Chicago
Howard Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Maynard I. Shapiro, Chicago
Joseph Skom, Chicago
Cyril C. Wiggishoff, Chicago

To serve from Jan. 1, 1983 to Dec. 31, 1984

(Elected April 17, 1982)

David S. Fox, Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John J. Ring, Mundelein
P. John Seward, Rockford
George T. Wilkins, Granite City

Honorary Members

Walter C. Bornemeier, Saratoga, California
Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, New York

Alternates

To serve from Jan. 1, 1982 to Dec. 31, 1983

(Elected April 7, 1981)

Alfred Clementi, Arlington Heights
Allan Goslin, Streator
Robert C. Hamilton, Chicago
A. Beaumont Johnson, Elgin
Harold Lasky, Chicago
Michael Nieder, Chicago
Arthur Traugott, Urbana
Ronald Welch, Belleville
Fred Z. White, Chillicothe

To serve from Jan. 1, 1983 to Dec. 31, 1984

(Elected April 17, 1982)

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
Robert P. Johnson, Springfield
Alfred J. Kiessel, Decatur
Clifton L. Reeder, Wilmette
Harry Springer, Chicago
Joseph Perez, Rockford

IMPAC

Illinois State Medical Society
Political Action Committee
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

NONPARTISAN

NOTIFICATION OF ANNUAL IMPAC MEETING

The 1983 Annual Meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 22, 1983, immediately following the adjournment of the ISMS House of Delegates:

11:15 a.m. (approximately)
Red Laquer Room
Palmer House Hotel
Chicago, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1983 IMPAC Nominating Committee has met and nominated the following individuals for membership in the IMPAC Council:

Howard C. Burkhead, M.D., Evanston
Robert D. Dooley, M.D., Oak Brook
Theodore Grevas, M.D., Rock Island
Mrs. Earl (Jane) Klaren, Libertyville
Paul F. Mahon, M.D., Springfield
George T. Mitchell, M.D., Marshall
Harry A. Springer, M.D., Winnetka
Patrick R. Staunton, M.D., Oak Park
Mrs. Alan (Pam) Taylor, Danville
George T. Wilkins, Jr., M.D., Edwardsville

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

Program Summary By Days

ISMS Annual Meeting

April 20-24, 1983 — Palmer House, Chicago

Wednesday, April 20, 1983

5:00 p.m.	ISMIE Membership Meeting
	ISMIE Board Meeting immediately following Membership Meeting

Thursday, April 21, 1983

9:00 a.m.	Board of Trustees Meeting

Friday, April 22, 1983

7:30 a.m.	Board of Trustees Meeting
7:30 a.m.	Rules and Order of Business Meeting
8:00 a.m.	Registration
8:00 a.m.	CMS Caucus
8:30 a.m.	Meeting of Reference Committee Members
8:30 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:15 a.m.	IMPAC Annual Meeting
11:30 a.m.	District Meetings
11:30 a.m. -1:30 p.m.	Delegates' Buffet
1:30 p.m.	Reference Committees
5:00 p.m.	ISMS/ISMSA Benefit Auction

Saturday, April 23, 1983

7:30 a.m.	Public Affairs Breakfast
8:00 a.m.	Registration
8:30 a.m.	CMS Caucus
9:00 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:00 a.m.	Medical Student Section
11:00 a.m.	Resident Physicians Section
11:30 a.m.	Fifty Year Club
1:00 p.m.	CMS Caucus (if necessary)
1:30 p.m.	Credentials Committee
2:00 p.m.	House of Delegates
4:45 p.m.	District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, Caucus
7:30 p.m.	President's Night—"Masked Costume Ball"

Sunday, April 24, 1983

7:30 a.m.	Board of Trustees Meeting
8:00 a.m.	Registration
8:30 a.m.	Credentials Committee
9:00 a.m.	House of Delegates
	Board of Trustees Reorganization Meeting immediately following House adjournment

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The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (October). Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____ CITY: _____ ZIP: _____

ADDRESS: _____

TELEPHONE: ( ) _____

COUNTY MEDICAL SOCIETY: _____

MEDICAL SPECIALTY AND TYPE OF PRACTICE: _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

YOU'RE INVITED

To a complimentary Public Affairs Breakfast on Saturday, April 23, 1983, 7:30 a.m., Palmer House Hotel, Chicago



Guest Speaker

OTIS R. BOWEN, M.D.

Former Governor

State of Indiana

Tickets for the breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.

For further information, please contact James Tierney at ISMS offices, 55 East Monroe, Suite 3510, Chicago 60603. Telephone (312) 782-1654.

Schedule of Associated Meetings

Wednesday, April 20, 1983 **5:00 p.m.**

Illinois State Medical Inter-Insurance Exchange
Annual Meeting of Members

The principle purpose of this meeting will be the election of members to the Exchange Board of Governors for the 1983/84 term. All members of the Exchange are urged to participate either by personal attendance or by timely execution of their proxy statement.

Friday, April 22, 1983 **11:15 a.m.**

Illinois State Medical Society Political Action Committee
Annual Meeting

Friday, April 22, 1983 **5:00 p.m.**

ISMS/ISMSA Benefit Auction

Saturday, April 23, 1983 **7:30 a.m.**

ISMS Public Affairs Breakfast

Otis R. Bowen, M.D.
Former Governor of Indiana

Tickets available at ISMS registration desk

Saturday, April 23, 1983 **11:00 a.m.**

Medical Student Section

Annual business meeting and election of officers

Saturday, April 23, 1983 **11:00 a.m.**

Resident Physicians Section

Annual Business meeting and election of officers

Saturday, April 23, 1983 **7:30 p.m.**

President's Night

"A Masked Costume Ball"

ISMS Auxiliary
Fifty-Fifth Annual Meeting
Palmer House Hotel
Convention Program

Thursday, April 21

10:00 a.m.-12:00 noon	Pre-Convention Board of Directors Meeting
12:00 noon-2:00 p.m.	Pin and Gavel Luncheon (Past Presidents Only)
1-4:00 p.m.	House of Delegates Registration
2:00 p.m.	First House of Delegates Session Introductions Reading of Rules Budget Reading and Approval Bylaws Discussion and Approval President's Report to House of Delegates Memorial Service
6:30 p.m.	Board of Directors Dinner Hospitality Suite following

Friday, April 22

7:30-8:30 a.m.	Exercise and Nutrition/Health Breakfast, Suzanne Meirink
9:00 a.m.	Keynote Speaker: Glenda Bates, AMAA President-Elect
9:30-11:30 a.m.	Workshop: "First and Lasting Impressions" Loretta A. Malandro, Malandro Associates, Inc.
11:30 a.m.-12:15 p.m.	Workshops: "Fetal Alcohol Syndrome"—Diane Hinderliter "Widows Might"—Delores Haugh
12:30-2:00 p.m.	President's Luncheon
2-3:30 p.m.	Second House of Delegates Session County Reports—"Your County in Review"
3:30-4:30 p.m.	Workshop: "Time Management" David L. Schmidt, President, Management Development Associates
6-8:30 p.m.	ISMS/ISMSA Benefit Auction

Saturday, April 23

7-9:00 a.m.	ISMS Public Affairs Breakfast
9-10:00 a.m.	Third House of Delegates Session Opening Remarks Election Instruction Period Nominations for Nominating Committee and AMAA Delegates Elections
10-11:00 a.m.	Workshop: "Basics of Parliamentarian Procedures" Russell G. Miller, J.D., Moss, Miller, and Josephson
11:00 a.m.	Award Presentations
12:00 noon	Installation Luncheon Annual Meeting Adjournment
2:00 p.m.	Board of Directors Picture
2:15 p.m.	Post Convention Board of Directors Meeting
7:30 p.m.	ISMS President's Night—A Masked Costume Ball Honoring Cyril C. Wiggishoff, M.D.

Illinois State Medical Society
and the
Illinois State Medical Society Auxiliary

present a

Benefit Auction

to support the

ISMS Financial Assistance to Medical Students Program

Through the Educational and Scientific Foundation

Friday, April 22, 1983
Palmer House, Chicago

4:00-5:00 p.m.: Items on Display
5:00-6:00 p.m.: Hors d'oeuvres & Cash Bar
6:00-8:30 p.m.: Auction

$10 per person donation for admission*

Items to be auctioned include
Antiques
Memorabilia
Novelties
Liquor
Handicrafts

All proceeds to benefit the new ISMS medical student financial assistance program scheduled for operation by fall semester 1983. If you wish to donate an item for auction, contact Perry Smithers, ISMS Headquarters, 312/782-1654.

Join us for an evening of fun and surprises!

*Contributions are normally tax deductible.

CONVENTION '83

The 143rd Annual Meeting
of the
Illinois State Medical Society
will be held at the
Palmer House
State and Monroe Streets
Chicago, Illinois
April 22-24,1983

- **ISMS House of Delegates**
- **Gala President's Party "Masked Costume Ball"**
- **Annual IMPAC Meeting**
- **Public Affairs Breakfast**

Further information about convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Phone: (312) 782-1654.

PLAN NOW TO ATTEND . . . . CONVENTION '83

PALMER HOUSE HOTEL
State and Monroe Streets
Chicago, IL 60603

ISMS/ISMSA ANNUAL MEETING
April 22-24, 1983
Palmer House, Chicago

Name (please print) _____

_____

Company Name _____

Address _____

City _____ State _____ Zip _____

Arrival _____ Hour _____am/pm Departure Date _____

PLEASE CHECK RATE DESIRED

Singles: ☐ $65
Doubles: ☐ $85
Twins: ☐ $85

Parlor & 1 Bedroom Suites: ☐ $160 & up
Parlor & 2 Bedroom Suites: ☐ $375 & up

PALMER HOUSE TOWERS

Singles: ☐ $ 95 ☐ $105 ☐ $115 ☐ $130
Doubles: ☐ $115 ☐ $125 ☐ $135 ☐ $150
Twins: ☐ $115 ☐ $125 ☐ $135 ☐ $150

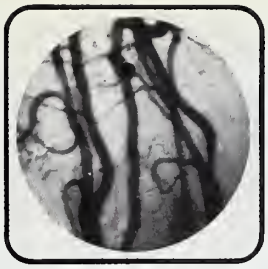
Parlor & 1 Bedroom Suites: ☐ $370 & up
Parlor & 2 Bedroom Suites: ☐ $520 & up

For better choice of accommodations, early reservations are suggested. If rate requested is not available, the next available rate will be confirmed.

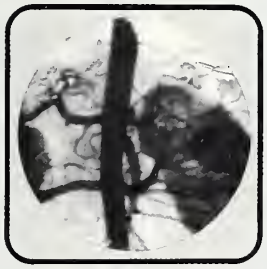
Rooms will be held until 6:00 p.m. on stated date of arrival, unless a later time is confirmed.

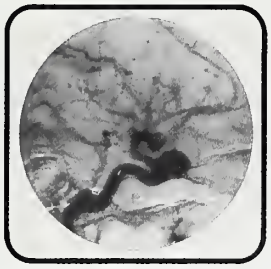
All room rates are subject to additional charges equivalent to state, county and city taxes.

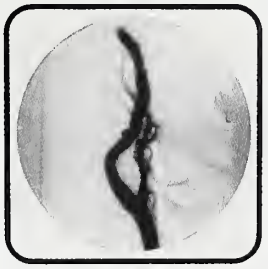
What Every Physician and Hospital Administrator











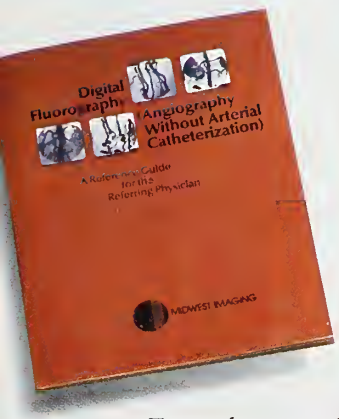
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As a service to the medical community, Midwest Imaging has compiled a comprehensive reference guide which describes applications and clinical experience at major medical centers. Please contact us by phone, 1 + (312) 588-7000, or use the enclosed reply card to obtain your copy or to request professional consultation on your requirements.

MIDWEST IMAGING

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Glendale Heights, IL 60137

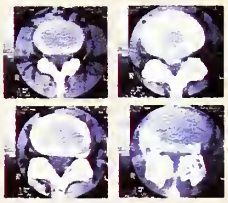
4007 N. Monticello
Chicago, IL 60618

For information—312/588-7000 **For scheduling dial: 312-I•M•A•G•I•N•G or (312/462-4464)**

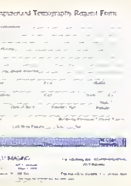
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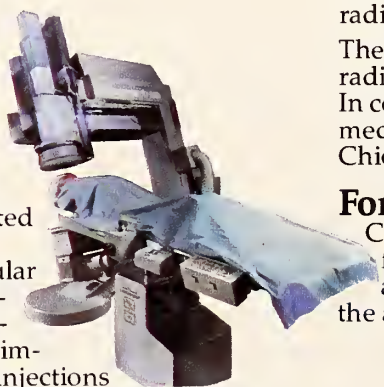
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May 2-6
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May 16-21
Specialty Review in Orthopedics
May 22-28
Specialty Review in Family Practice
May 31-June 11
Specialty Review in Pediatric Cardiology
June 8-11
Clinical Medicine Update
June 13-17
Scientific and Practical Approaches ta the Treatment of Obesity
June 20-22
Uralagic Oncalagy
July 11-14
Practical Office Dermatalagy
July 11-15
Enviranmental Medicine
July 18-22
Specialty Review in Pediatrics
July 18-23
High Risk Obstetrics
July 27-29

For further information write or call:

The Cook County Graduate School of Medicine
707 South Wood Street
Chicago, Illinois 60612
(312) 733-2800

ISMS 1983 Travel Programs

The following ISMS-sponsored programs have been scheduled for 1983:

March 16—*Caribbean Air/Sea Cruise:* St. Thomas, Antigua, Barbados, Martinique and St. John

May 29—*Dutch Waterways:* two week holiday including cruise of the canals and inland sea of Holland, plus Paris and Geneva.

June 28—*Orient Express:* Vienna, Venice, the Orient Express Train and Paris

July 28—*Main River:* Wiesbaden, six nights cruising on the Main River and Munich

August 14—*Canadian Rockies:* ten day tour to include Calgary, Banff, Lake Louise, Jasper State Park and Vancouver

September—*Spain and Portugal*

October 20—*Greek Isles Air/Sea Cruise:* a 14 day adventure to include Athens and a seven night cruise to Rhodes, Santorini, Mykonos, Delphi and the Corinth Canal.

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS and auxiliary members at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact the travel department at ISMS headquarters.



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Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

APRIL

Cordiology

Post Myocardiol Inforction Monogement
For: MD's. Symposium, April 8, 1:00 p.m., Taylarville. **Sponsor:** SIU School of Medicine, P. O. Bax 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Emergency Medicine

For: MD's. Symposium, April 20-21, Moline. **Sponsor:** Moline Public Hospital, 635 10th Avenue, Moline 61265. **Fee:** $60. **Reg. limit:** yes. **Credit:** Category 1, 12 hours. **Contact:** M. J. Miller, RN. **Phone:** 309/757-3288.

Gynecology

Current Management of Problems in Gynecology
For: Gynecologists. Course, April 22-23, Ritz Carlton Hotel, Chicago. **Sponsor:** Dept. of OB/GYN, U of Chicago, CME, 950 E. 59th St., Chicago 60637. **Fee:** $195; $100, residents. **Credit:** Category 1, 9 hours; ACOG, 9 hours. **Contact:** Mary Ann Dillan. **Phone:** 312-962-1056.

Medicine

Gostrointestinal Problems
For: MD's. Symposium, April 19, 7:00 p.m., Vandalia. **Sponsor:** SIU School of Medicine, P. O. Bax 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Medicolegol

Medicalegal Investigatian of Death
For: Pathologists. Course, April 14-16, Hotel Pontchartrain, Detroit, MI. **Sponsor:** Wayne State University School of Medicine, CME, 4201 St. Antoine, 4H UHC, Detroit, MI 48201. **Phone:** 313/577-1180.

Neurorodiology

Neuroradiology Review Course
For: General Radiologists, Neuroradiologists, Neurosurgeons. Course, April 30-May 1, Marriatt Hatel, Oak Brook. **Sponsor:** Loyola University Center CME, 2160 S. First Ave., Maywood 60153. **Fee:** $140; $80, residents. **Credit:** Category 1, 15 hours. **Contact:** Linda Gunzburger, PhD. **Phone:** 312-531-3237.

OB/GYN

Immunology of Reproduction
For: MD's. Lecture, April 22, 8:00 a.m., Chicago. **Sponsor:** UHS/CMS. **Cosponsor:** Coak County Hospital, 1825 W. Harrison St., Division of Gynecologic Oncology, Chicago 60612. **Reg. deadline:** 2/15. **Reg. limit:** none. **Credit:** Category 1, 8 haurs. **Contact:** Ben Blivaiss, PhD. **Phone:** 312-578-3215.

OB/GYN

Symposium on Obstetrics & Gynecology
For: MD's. Symposium, April 7-8, St. Louis, MO. **Sponsor:** Washingtan University School of Medicine, CME, Bax 8063, 660 S. Euclid, St. Lauis, MO 63110. **Fee:** $200. **Reg. limit:** 150. **Credit:** Categary 1, 13½ haurs; AAFP Prescribed, 13½ hours; AOA, 13½ hours; 13½ cognates. **Contact:** Loretta Giacaletto. **Phone:** 314-367-9673.

Office Manogement

Office Manogement ond Computers
For: MD's. Symposium, April 7, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, P. O. Bax 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Pothology

Specialty Review in Pathalogy/Anatamic
For: Pathologists. Lecture, April 11 (6 days), Chicogo. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $425. **Reg. limit:** 90. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathology

Specialty Review in Pathalogy/Clinical
For: Pathologists. Lecture, April 18 (5 days), Chicogo. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 90. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pothology

Liver ond GI Clinico-Pathalogic Conference
For: MD's. Lecture, April 26, 4:30 p.m., North Chicogo. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivoiss, PhD. **Phone:** 312-578-3215.

Pothology

Hematopothology, Leukemias & Leukemaid Reactions
For: Pathologists. Lecture, April 11, 7:30 p.m., Drake Hotel, Chicago. **Speaker:** J. Vardimon, MD. **Sponsor:** Chicago Pathology Society, c/a Marshall Short, MD, Laretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312-626-4300 x 383.

Pediotrics

New Frantiers in Developmental Pediotrics
For: Pediatricians. Symposium, April 27-28, Hilton Inn of Oak Lawn. **Sponsor:** Christ Hospital, 4440 W. 95th St., Oak Lawn 60453. **Reg. deadline:** 4/12. **Fee:** $100. **Credit:** Category 1, 10 hours. **Contact:** Cheryl Ehrhart. **Phone:** 312-857-5682.

Pulmonory Diseoses

Pulmanary Diseases Symposium
For: MD's. Symposium, April 28, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Rodiology

Radiology Updote
For: MD's. Symposium, April 13, 6:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P. O. Bax 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Rodiology

Specialty Review in Radiology
For: Radiologists. Lecture, April 25-29, Chicago. **Speaker:** Rogelio Moncada, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Rheumotology

Rheumotology
For: MD's. Symposium, April 30, 1:00 p.m., Mt. Carmel. **Sponsor:** SIU School of Medicine, P. O. Bax 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Surgery

Fiberaptic Colanascopy
For: Surgeons. Lecture, April 27-29, Chicogo. **Speaker:** Herand Abcarian, MD. **Sponsor:** Coak County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Flexible Fiberoptic Sigmaidoscopy
For: Surgeons. Lecture, April 23, Chicogo. **Speaker:** Herand Abcarion, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $125. **Reg. limit:** 60. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Urology

Speciolty Review in Urology
For: Urologists. Lecture, April 25-30, Chicago. **Speakers:** Drs. Thomas John ond Irving Bush. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 200. **Credit:** Category 1, 53 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Utilizotion Review

Third Party Payers
For: MD's. Lecture, April 17, Marriott Hotel, Oak Brook. **Sponsor:** Illinois Regional Chapter of American College of Utilization Review Physicians, c/o 1108 N. Second Street, Harrisburg, PA 17102. **Reg. deodline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 5 hours. **Contact:** Betty Hamman. **Phone:** 717-697-4428.

MAY

Anesthesiology

Speciolty Review in Anesthesiology
For: Anesthesiologists. Lecture, May 1-6, Chicago. **Speaker:** Alon Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $525. **Reg. limit:** 450. **Credit:** Category 1, 54 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Bock Poin

Back Pain Conference
For: MD's. Conference, May 13-14, Madison, WI. **Sponsor:** U of WI—Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** TBD. **Reg. limit:** none. **Credit:** TBD. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Cardiac Rehabilitation

Cardiac Rehabilitation Symposium
For: MD's. Symposium, May 4-6, Milwaukee, WI. **Sponsor:** U of WI—Extension, CME, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $250, MD; $155, other. **Reg. limit:** none. **Credit:** TBD. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Cardialagy

Treatment of Acute Myocardial Infarction
For: MD's. Symposium, May 18, 6:00 p.m., Highland. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Dermatalogy

Dermabrasion, Chemical Peel, Silicone, Collagen
For: Dermatologists. Workshops/lectures, May 18-21, Chicago. **Sponsors:** The American Society for Dermatologic Surgery; Northwestern University, 303 E. Chicago Ave., Chicago 60611. **Fee:** none. **Reg. limit:** 100. **Credit:** Category 1. **Contact:** Henry Roenigk, Jr., MD. **Phone:** 312-649-8173.

Family Medicine

Specialty Review in Family Practice
For: FP's. Lecture, May 31-June 11, Chicago. **Speaker:** Harry Morchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $600. **Reg. limit:** 90. **Credit:** Category 1, 91 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Medicine

Gastroenteralagy
For: MD's. Symposium, May 26, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Medicine

Dermatologic Therapeutics in General Practice
For: MD's. Symposium, May 17, 7:00 p.m., Effinghom. **Fee:** $40. **Reg. limit:** none. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Ob-Gyne

Specialty Review in Ob-Gyne, Part 1
For: Obstetricians, Gynecologists. Lecture, May 16-21, Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $425. **Reg. limit:** none. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Orthopedics

Specialty Review in Orthopedics
For: Orthopedic Surgeons. Lecture, May 22-28, Chicago. **Speakers:** Peter Altner, M.D.; James Callahan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** none. **Credit:** Category 1, 68 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Pathalagy

Non-Hodgkin's Lymphoma
For: MD's. Lecture, May 9, 7:00 p.m., Chicago. **Speaker:** R. J. Hortsock, MD. **Sponsor:** Chicago Pathology Society, c/o Morshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Reg. deadline:** 4/29. **Fee:** dinner only. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312-626-4300.

Pediatrics

Pediotrics
For: MD's. Symposium, May 25, 1:00 p.m. Noshville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Surgery

Fiberoptic Esophogogastric Endoscopy
For: Surgeons, Internists. Lecture, May 2-4, Chicago. **Speaker:** C. Thomas Bambeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Advances in Surgery
For: General and Speciolizing Surgeons. Lecture, May 2-6, Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $375. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, M.D. **Phone:** 312/733-2800.

Surgery

The Management of Burn Patients Today
For: MD's. Symposium, May 26, Springfield. **Spansor:** SIU School of Medicine, P. O. Box 3926, Springfield, 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

JUNE

Cardiology

Cardiac Rehabilitation
For: GP's, FP's, Internists. Seminar, June 10-11, Hyatt Regency, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr., E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** $260. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

Geriatrics

Geriotric Problems
For: MD's. Symposium, June 2, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Headache

Annual Meeting
For: MD's, DO's, DDS's. Lectures, June 24-26, Four Seasons Hotel, Toronto, Canada. **Sponsor:** American Association for the Study of Headache, 5252 N. Western Ave., Chicago 60625. **Reg. deadline:** 6/1. **Fee:** $100, non-members. **Reg. limit:** none. **Credit:** Category 1, 18 hours; AAFP Prescribed, 18 hours; AOA, 2-D. **Contact:** Seymour Diamond, MD. **Phone:** 312/878-5558.

Internal Medicine

Internal Medicine Symposium
For: MD's. Symposium, June 17-18, Springfield. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

OB-GYN

Ob-Gyn Review Course
For: MD's. Course, June 6-11, Americana Congress Hotel, Chicago. **Sponsors:** 7 medical schools in Illinois. **Fee:** $450; $350, residents. **Reg. limit:** none. **Credit:** Category 1, 34 hours; ACOG cognates, 34. **Contact:** CME, University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. **Phone:** 312/962-1056.

Pathology

Liver & GI Clinico-Pathologic Conference
For: MD's. Lecture, June 28, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivoiss, PhD. **Phone:** 312/578-3215.

Pathalagy

Laboratory Evaluation of Cerebrospinal Fluid
For: Pathologists. Lecture, June 13, 7:30 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Shart, M.D., Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Cosponsor:** Michael Reese Hospital. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312/626-4300 x 383.

Pulmanary Disease

Pulmanary Medicine Update
For: MD's. Conference, June 17-18, Madison, WI. **Sponsor:** University of WI—Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category TBD. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

AMA VIDEO CLINICS

The AMA has recently announced four additions to its Video Clinic Library:

Rehabilitation after Myocardial Infarction

Obesity and Overweight

The Anemic Patient

Dementia: A Clinical Approach

Each Video Clinic includes a color tape, study guide, self-assessment tests and forms for CME credit.

For additional information contact:

Division of Marketing and
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Chicago, IL 60610
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REMINDER TO ILLINOIS CME SPONSORS

Does "educational jargon" confuse you?
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ICCME staff is available to visit your hospital or specialty society to offer assistance with the above and answer any other questions you may have concerning the Illinois Criteria for Accreditation. We'll even review your Self-Analysis form prior to submission for your site survey!

To arrange for a personal consultation (no charge), contact the Illinois Council on Continuing Medical Education at (312) 236-6110.

EKG

(Continued from page 162)

Answers: 1. A, B, D
2. E

The first six beats on the top ECG rhythm strip are pacemaker beats. Premature ventricular beats alone and in couplets or pairs activate the demand mode of the pacemaker toward the end of this strip. P waves can be seen marching through the QRS in the top strip for a diagnosis of atrioventricular dissociation. Bursts of a wide QRS tachycardia can be seen in each of the bottom two ECG strips. This tachycardia is occurring at a rate of over 230 beats per minute. Close scrutiny of these bursts of tachycardia show P waves marching through the QRS here, too. Atrioventricular dissociation with a wide QRS tachycardia suggests this is ventricular in origin.

Electrocardiographically, ventricular tachycardia is called ventricular flutter when no clear distinction can be made between the QRS and the T wave. Essentially, ventricular flutter occurs at very fast rates and resembles a sine wave. These beats were associated with no palpable pulses or measurable blood pressure. Despite the use of the pacemaker with drugs, her ventricular arrhythmias could not be controlled and she died in intractable ventricular fibrillation. Post mortem examination showed severe right ventricular hypertrophy and moderate atherosclerosis of the pulmonary artery. The coronary arteries were normal. Sections of the lung showed marked medial arteriolar hypertrophy. These findings were compatible with a diagnosis of primary pulmonary hypertension. All of the answers in question two are true. Most patients with pulmonary hypertension are female and come to medical attention relatively late in the course of the disease. The symptoms which prompt a visit are often due to low cardiac output or hypoxemia. By the time these develop, irreversible pulmonary vascular changes have occurred. Pulmonary vasodilators, digitalis, and anticoagulation are all used with little effect. Unfortunately there is no good treatment for primary pulmonary hypertension at this time. ◀

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

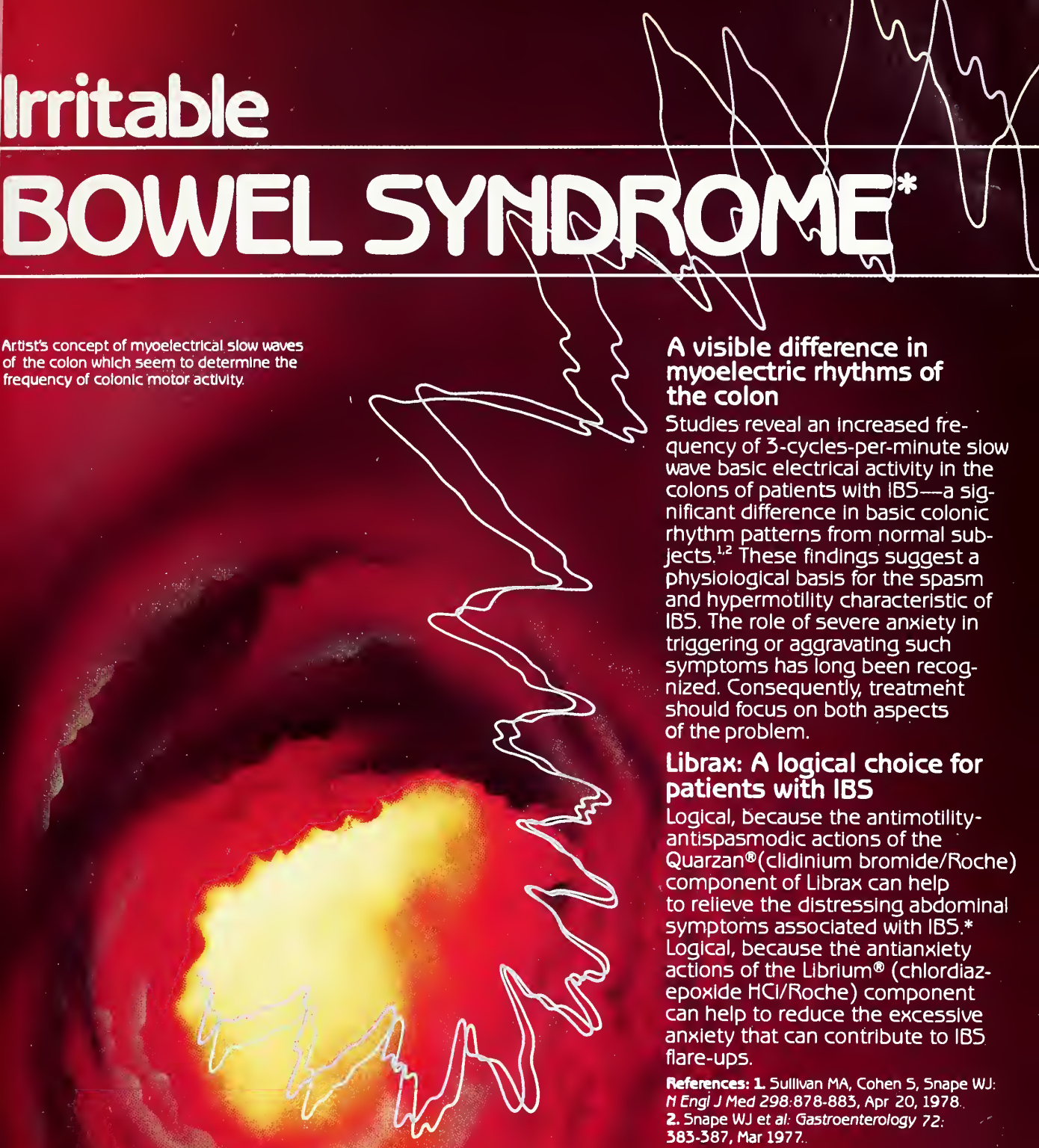
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Irritable BOWEL SYNDROME*



Artist's concept of myoelectrical slow waves of the colon which seem to determine the frequency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

Librax: A logical choice for patients with IBS

Logical, because the antimotility-antispasmodic actions of the Quarzan®(clidinium bromide/Roche) component of Librax can help to relieve the distressing abdominal symptoms associated with IBS.* Logical, because the antianxiety actions of the Librium® (chlordiazepoxide HCl/Roche) component can help to reduce the excessive anxiety that can contribute to IBS flare-ups.

References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med* 298:878-883, Apr 20, 1978. **2.** Snape WJ *et al: Gastroenterology* 72: 383-387, Mar 1977.

Specify Adjunctive **Librax®**

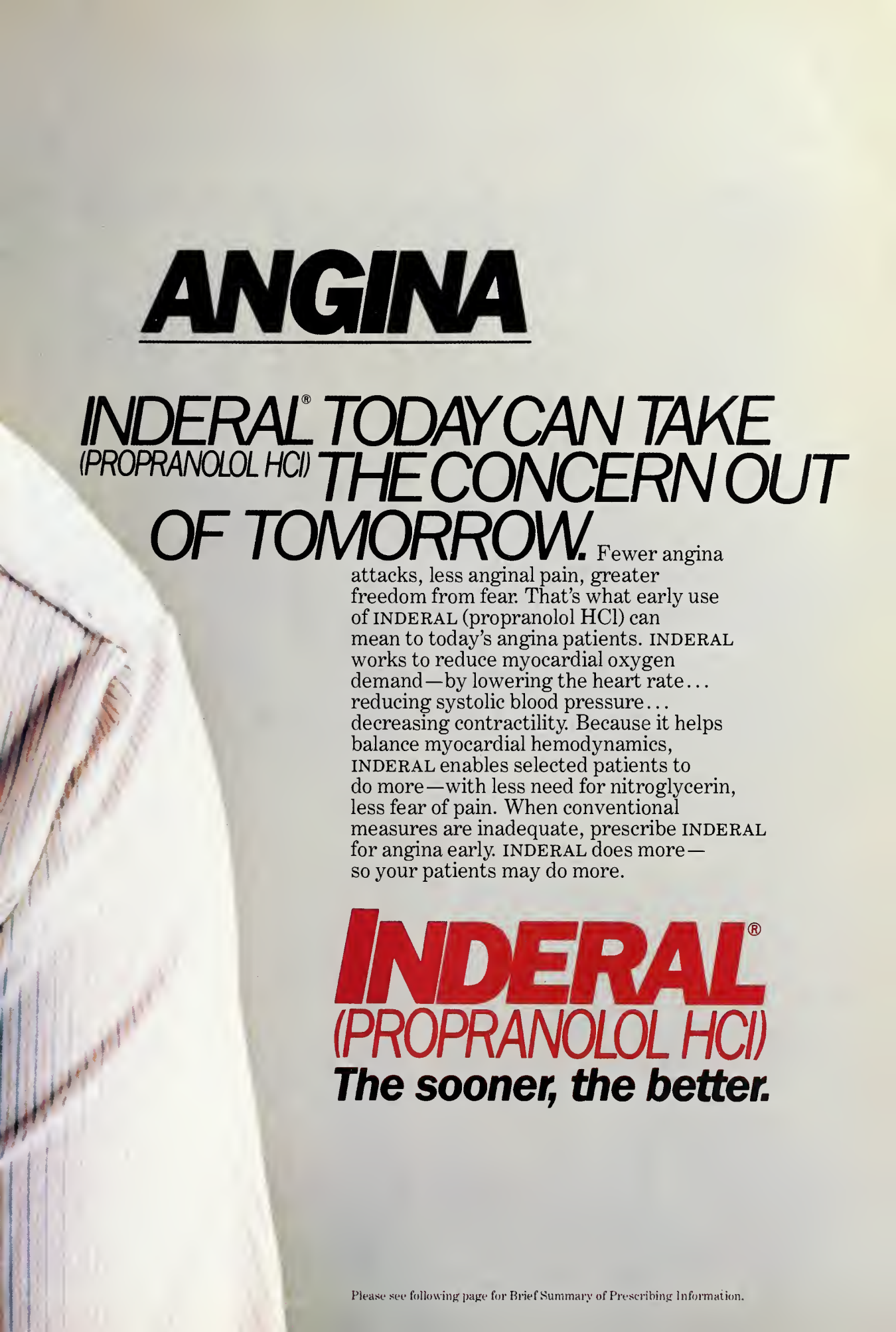
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

ROCHE®

*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.





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Fewer angina attacks, less anginal pain, greater freedom from fear. That's what early use of INDERAL (propranolol HCl) can mean to today's angina patients. INDERAL works to reduce myocardial oxygen demand—by lowering the heart rate... reducing systolic blood pressure... decreasing contractility. Because it helps balance myocardial hemodynamics, INDERAL enables selected patients to do more—with less need for nitroglycerin, less fear of pain. When conventional measures are inadequate, prescribe INDERAL for angina early. INDERAL does more—so your patients may do more.

INDERAL®
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The sooner, the better.

Please see following page for Brief Summary of Prescribing Information.

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THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD.



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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE. In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn. b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY. Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System*: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal*: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic*: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory*: bronchospasm. *Hematologic*: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous*: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings*: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS

Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTABLE

Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

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Viewbox

(Continued from page 160)

DIAGNOSIS: M. TUBERCULOSIS OSTEOMYELITIS.

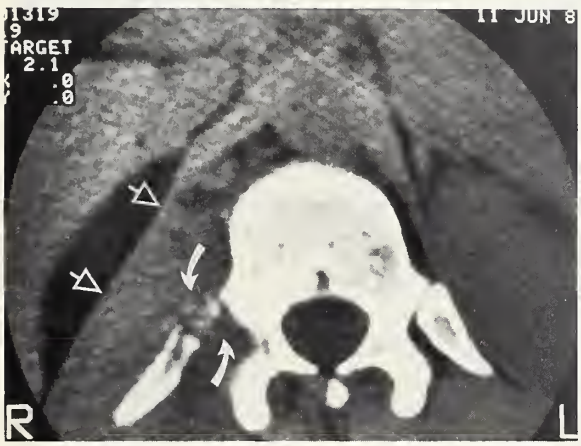


Figure 3
Computed tomographic section through T 12 shows destruction of the proximal right twelfth rib (closed arrows) and an associated soft tissue mass (open arrows).



Figure 4
AP view of the lumbar spine shows calcifications in paravertebral psoas muscle abscesses.

Figure 1 is the plain radiograph corresponding to the computed tomographic section (Figure 3) and shows destruction of the right twelfth rib. Figure 2 shows a lytic lesion of the proximal tibia.

The duration of this patient's complaints, lack of systemic symptoms, and signs of localized inflamation are against the diagnoses of leukemia, lymphoma, and metastatic seminoma. Acute leukemia may occasionally cause bony lesions in adults. Lesions are characteristically destructive, may cause transverse metaphyseal lucencies in long bones, and may provoke periosteal new bone formation. Lymphoma sometimes produces "gouge" defects in vertebral bodies, and can cause lytic, sclerotic or mixed lytic-sclerotic lesions. Differentiation from skeletal tuberculosis may be difficult. Metastases may cause multiple areas of bone destruction. Coccidiomycosis can involve both the axial appendicular skeleton and may be impossible to differentiate from skeletal tuberculosis except by culture. A history of travel to endemic areas such as the southwestern U.S. would be important.

Skeletal Tuberculosis

Improvements in health care, living conditions, and the introduction of effective antituberculous drugs have contributed to the decline in the incidence of pulmonary tuberculosis in the United States over the past two decades from 80,000 cases per year to less than 20,000 per year. However, tuberculosis remains a significant infectious disease problem in the U.S. Although the incidence of pulmonary tuberculosis has been on the decline, the number of new cases of extrapulmonic TB has remained constant at about 4,000 per year.[1,2] In one study, skeletal tuberculosis represented approximately 10% of extrapulmonic TB

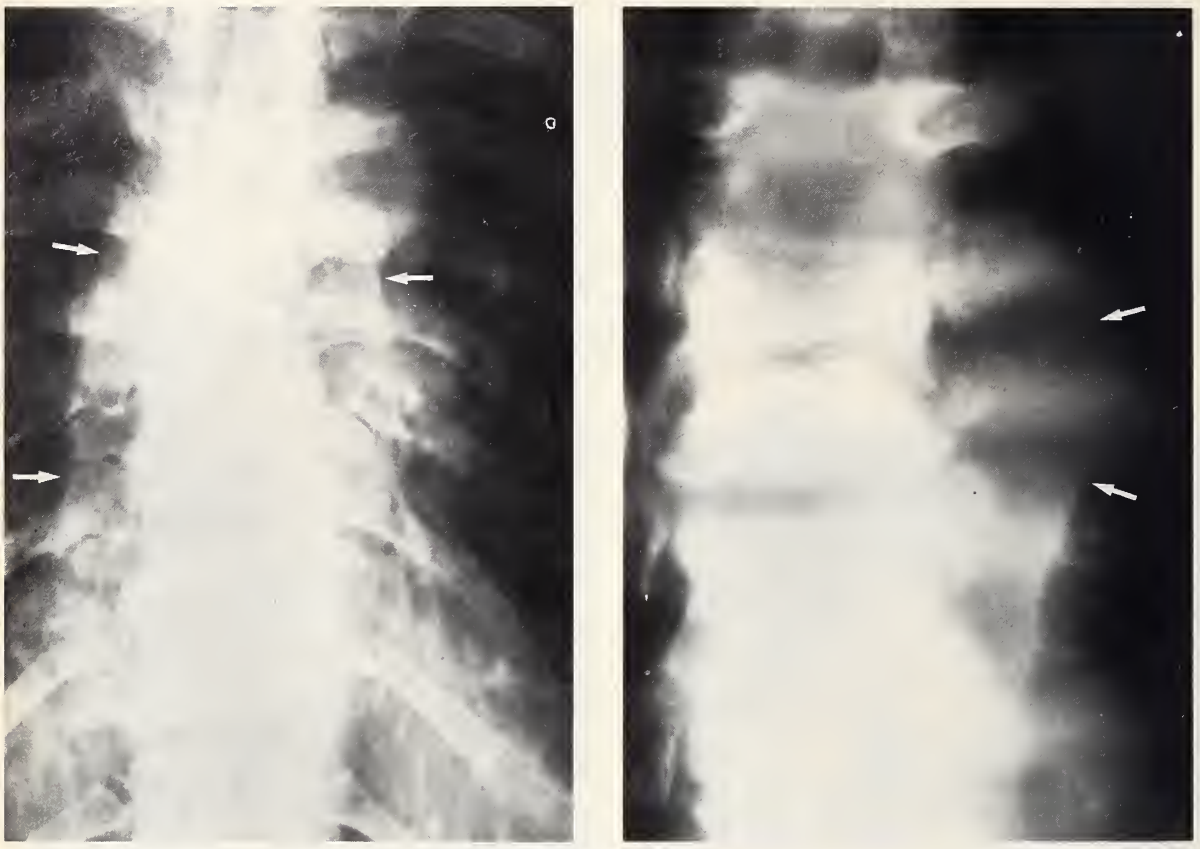


Figure 5A,B
(A) AP view of thoracic spine shows a tuberculous paraspinal "cold" abscess (arrows) and (B) tomography shows destruction of two adjacent vertebrae and a paraspinal mass (arrows).

or 1% of all cases of tuberculosis from 1969 to 1973.[3] Consequently, skeletal tuberculosis should be considered in the diagnosis of common orthopedic complaints.[4]

Clinical

Diagnosis depends upon maintaining a high degree of clinical suspicion. The onset of symptoms is insidious. Pain is a frequent presenting complaint and may be accompained by swelling or joint effusion.[5] Patients typically have symptoms ranging in duration from months to years before the diagnosis is made. A case of tuberculous arthritis of 33 years duration prior to diagnosis has been reported.[6] Other symptoms of tuberculosis, including anorexia and weight loss, and fever of undetermined origin, may be present. Tuberculosis of the spine with a paravertebral abscess should be considered when painless paravertebral swelling is encountered. A "cold abscess" (Figures 4 and 5) can arise either by direct extension from an area of vertebral osteomyelitis or from a fistulous tract.[7] Tuberculous spondylitis has even presented as a colonic perforation with a thigh abscess.[2] Neurologic deficits from nerve root or cord compression may result (Figure 7).

Spine

Only 5% of pyogenic osteomyelitis involves the spine, but spinal tuberculosis represents approximately 50% of skeletal tuberculosis.[8] The thoracic and lumbar spine are most frequently involved; cervical and sacral tuberculosis are uncommon. The infection usually begins in the anterior part of the vertebral body with subsequent spread to the intervertebral disc and adjacent vertebral body (Figure 5). Infection usually involves two adjacent vertebral bodies and the intervening intervertebral disc, although instances of tuberculosis of only one vertebral body and rare cases of neural arch involvement have been reported. Radiographically, bony destruction of

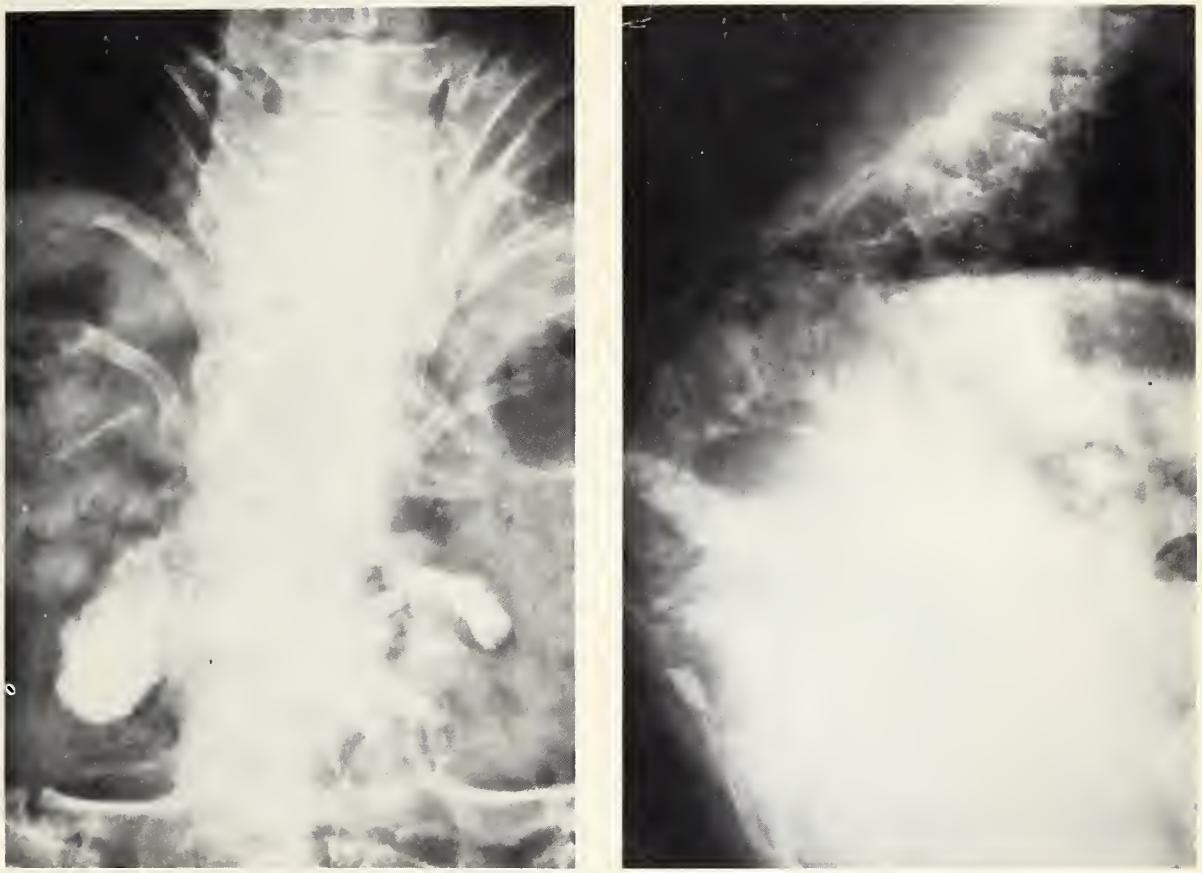


Figure 6A,B
(A) AP and (B) lateral views of the lower spine show a severe kyphotic deformity due to long standing tuberculous spondylitis. Also note symmetric calcified tuberculous psoas abscesses.

the anterior vertebral body is seen, along with narrowing of the intervertebral disc and similar destruction of the adjacent vertebra. The margin of the lesion is usually well circumscribed. As in all types of spinal osteomyelitis, loss of cortex is seen, but reactive sclerosis or periosteal reaction does not often occur.[5,9] More atypical findings including periosteal reaction and sclerosis have been reported in non-causasians, however.[9] With disease progression vertebral collapse and anterior wedging occurs leading to gibbus formation and subluxation (Figure 6).[5,9] In many patients the radiographic appearance of tuberculous infection is identical to that of pyogenic infection.

Soft tissue masses can be seen, especially in the cervical and thoracic spine. These are more difficult to detect in the lumbar region. Another distinct form of spinal tuberculosus is subligamentous infection. In this entity tuberculosis spreads superiorly and inferiorly beneath the anterior longitudinal ligament. Resultant erosions or "gouge" defects of the anterior vertebral bodies spare the disc space and may mimic lymphoma or aortic aneurysm (Figure 7).

Joints

Articular lesions occur next in frequency after spinal tuberculosis. Monoarticular disease is the rule. The hip is the most common site of occurrence, with knee closely following, although two series in the 1950's showed the sacroiliac joints to be most frequently involved.[5,9] Intercarpal and intertarsal infections happen less often. Tuberculous arthritis is an indolent process. The classic radiographic findings include late joint space narrowing, osteoporosis, and erosions of the non-weight bearing surfaces of the joint.

Erosions of the femoral head are common in the hip and with far advanced lesions *protrusio acetabuli* is seen. Marginal erosions, suprapatellar



Figure 7
Lateral view of the lumbar spine shows tuberculous destruction of two adjacent vertebral bodies and the intervertebral disc. Note "gouge" defect (arrow) in another vertebra which indicates subligamentous spread of disease.

effusions, osteoporosis and finally condylar collapse characterize tuberculosis infection in the knee joint.[9] Widening of the joint space secondary to erosion of the articular surfaces and marginal sclerosis are commonly encountered in the sacroiliac joints. Only one sacroiliac joint is usually involved.

Long Bones

Individual lesions in the long bones are often metaphyseal in location owing to the favorable vascularity in this region (Figure 8). The lesions are usually destructive. Disseminated cystic lesions are a rare presentation. Tuberculous dactylitis of the long bones of the hand usually occurs in children but may also be encountered in adults.[5]

Differential Diagnosis

The differential diagnosis of skeletal tuberculosis includes osteomyelitis, inflammatory arthridities, and neoplasm. The duration of symptoms can aid in distinguishing TB from pyogenic osteomyelitis. In one series 80% of patients with TB had symptoms for greater than 6 months and 40% for greater than one year prior to diagnosis, while in patients with bacterial osteomyelitis, 80% had symptoms for less than 3 months.[5,10] Periosteal or endosteal reaction is less frequent in tuberculous osteomyelitis than in pyogenic osteomyelitis, but the two may be indistinguishable on radiographs.

Articular changes associated with tuberculosis are delayed compared to bacterial infection since proteolytic enzymes are absent from the tuberculous exudate. Localized osteoporosis with marginal joint erosions may mimic rheumatoid arthritis, but the fact that rheumatoid and other arthridities are usually polyarticular helps to distinguish them.

A destructive process in a single vertebral body is most often due to neoplasm and only rarely seen in conjunction with TB. Involvement of three vertebral bodies is uncommon in any osteomyelitis, including that due to TB. Additionally, neoplasm often involves the pedicles and neural arch, but this is rare with TB. The loss of intervertebral disc height found with TB does occur with metastatic disease but less often and to a lesser extent than with TB. Lymphoma may mimic subligamentous TB.

Tuberculous dactylitis sometimes cannot be separated radiographically from other causes of expansile dactylitis including sickle cell anemia, congenital syphilis, and granulomatous disease of childhood. Fibrous dysplasia and enchondroma may also resemble tuberculous dactylitis but are not associated with soft tissue swelling.[5]

Known tuberculous infection in another organ system is helpful, but 50% of patients with skeletal TB do not have radiographic evidence of pulmonary TB.[11] Infection is presumably due to reactivation of a previously seeded hematogenous focus.[11] Skin testing is negative in up to 20% of cases of isolated skeletal TB.[5] The erythrocyte sedimentation rate is usually below 50 in TB and may be normal. An ESR over 100 essentially proves pyogenic osteomyelitis in uncomplicated cases.[12]

Definitive diagnosis depends upon smears and cultures of joint fluid, abscesses or surgical biopsy specimens. Culture is necessary both to distinguish M. tuberculosis from rare infections with atypical mycobacteria including M. kansasi, M.



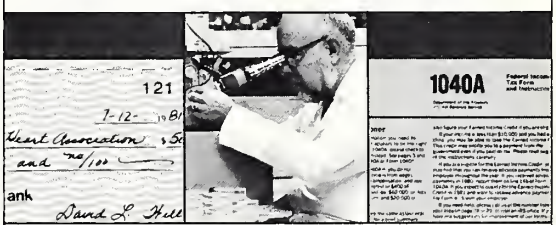
Figure 8
AP view of shoulder in a child shows metaphyseal destruction of the humerus (white arrows). Also note the presence of mediastinal lymphadenopathy due to primary TB (black arrows).

fortuitum, M. marinum, and M. intracellulare and to obtain sensitivities.[4,5] Spinal tuberculosis after BCG vaccination has also been reported.[13] Skeletal tuberculosis is usually associated with a scanty bacterial population and is therefore very amenable to treatment. Treatment, as for other forms of tuberculosis, is chemotherapy.[1] However, instances of very advanced disease or those in which neurological sequelae are present will require surgical debridement or decompression.[2,4,9,14,15] It may be necessary to administer anti-tuberculosus chemotherapy prior to culture results to prevent serious or debilitating sequelae.

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Abstracts of Board Actions

(Continued from page 171)

JCAH STANDARDS

A newly proposed standard for "organized" staff rather than "medical" staff has been developed by JCAH. Various commentaries and reviews were provided for the Board from individual members and Councils. After thorough review in the context of the role physicians play in providing medical care as well as the functions of hospitals, the Board agreed to (A) Inform the JCAH that ISMS strongly objects to the "organized staff" concept which undermines the quality of medical care provided within hospitals; and (B) Inform the AMA that ISMS opposes AMA's support of the proposed organized staff standards and strongly urges a re-examination of this position.

It was further noted that county medical societies and hospital medical staffs in Illinois will be informed of this action.

CONSTITUTION AND BYLAWS

Acting on a recommendation of the Committee on Constitution and Bylaws, and based on action at the 1982 Interim Session, the Board approved for introduction in the House of Delegates a resolution titled "Amendment to Chapter IV, Section 4 of the ISMS Bylaws" that would amend the bylaws so that an interim meeting shall occur only if called by the Board of Trustees.

POLICY COMMITTEE

The Board approved 17 policy statements based on House action at the 1982 Interim Session. These will be reflected in the 1983 Policy Manual.

AD HOC COMMITTEE TO ADJUST DOWNSTATE TRUSTEE DISTRICT BOUNDARIES

In response to Resolution 16 (A-82), the Board voted to recommend to the House of Delegates that the following adjustments of Downstate Trustee District Boundaries be accomplished: (A) that Du Page County become a single-county Trustee District, designated District 11; and (B) that the remainder of current District 11 be consolidated with current District 2.

DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Wytensin—4 mg. & 8 mg. tablets—(Guanabenz); Visken—5 mg. & 10 mg. tablets—(Pindolol); Norpace-CR—100 mg. & 150 mg. CR capsules—(Disopyramide); Cardiazem,—30 mg. & 6 mg. tablets—(Diltiazem HCl); Parlodel—5 mg. capsules—(Bromocriptine Mesylate); Timoptic—0.2%/0.5% ophth. solution—(Timolol Maleate) and Persa-Gel W—(Benzoyl Peroxide).

The Board also recommended that the following drugs not be included in the Drug Manual: Cefobid—1g/2g vial—(Cefoperazone); Ludiomil—75 mg. tablets—(Maprotiline HCl) and Naprosyn—500 mg. tablets—(Naproxen).

Referred back to committee, for further study, was the recommendation that all nitroglycerin transdermal patches and all maprotiline products be removed from the IDPA Drug Manual.

The Board further recommended that Penicillin G procaine in strengths of 10 ml. vial and 600,000U syringe be restored to the IDPA Drug Manual.

The Board directed that the following points be reviewed with IDPA: (A) That the following products not be eliminated from the IDPA Drug Manual: Ativan, Guaifenesin, Cyproheptadine, Promethazine tablets and syrup, Cortifoam and Proctofoam; (B) That IDPA install a toll-free phone line for physicians to obtain information on the drug program and prior approval process.

ADMINISTRATION

Informational reports were reviewed which reflected certain current activities. These included:

- Development of a staff resource to assist hospital medical staffs.
- Evaluation of current headquarters office computer and computer services.
- Review of various health planning legislation proposals.
- Current FTC rulings and legislation regarding FTC regulation and authority.
- Negotiations with IDPH regarding new health data regulations and the role of IDPH.
- Mandatory reporting rules and regulations and the implementation timetable, as well as the response being developed to comment on the rules.
- Meetings with the Governor and officials of IDPA regarding the slowdown in payment processing and budget cuts for payment to providers.

OTHER ACTIONS

In addressing various other issues, the Board:

- Adopted the following Board policy:
  "All materials developed and paid for by ISMS, in conjunction with our AMA Delegation, for support of ISMS candidates, remain the property of ISMS and may be released only upon approval by the ISMS Executive Committee."
- Directed that the appropriate ISMS council or committee review and participate in activities involving Peer Review Organization (PRO) regulations and groups who may apply as the PRO in Illinois.
- Agreed that the Third Party Payment Processes Committee should continue to meet with representatives of Chicago Community Trust and IDPA and report back to the Board about the feasibility of funding a joint demonstration project for medical services to IDPA recipients in Chicago.
- Reconsidered the following action taken at its September 11, 1982 meeting on the issue of Hold Harmless Agreements:
  ". . . The Committee believes that issues of this type may require negotiation and/or legal action depending upon individual case circumstances . . . The Board directed that 'Hold Harmless' complaints from members be directed to the Third Party Payment Processes Committee for discussion and recommendations for Board of Trustees action."
  Upon reconsideration, the Board approved the following in lieu of its previous direction: "That the Board of Trustees review, study and take such action as legal counsel would advise."
- Directed that ISMS co-sponsor, in name only, the second Illinois Statewide Conference on Child Passenger Safety, planned for June, 1983, by the Illinois Child Passenger Safety Association.
- Authorized a contribution of $150 to the Illinois Interagency Council on Smoking and Disease.
- Voted to not endorse the Illinois Continuity of Care Organization's 1983 program, titled, "Continuity of Care: New Issues—New Problems." However, should the organization have interest in ISMS' future endorsement and assistance in program planning, an ISMS representative will be provided. (ISMS policy states that input should be provided at the planning stage of a program.)

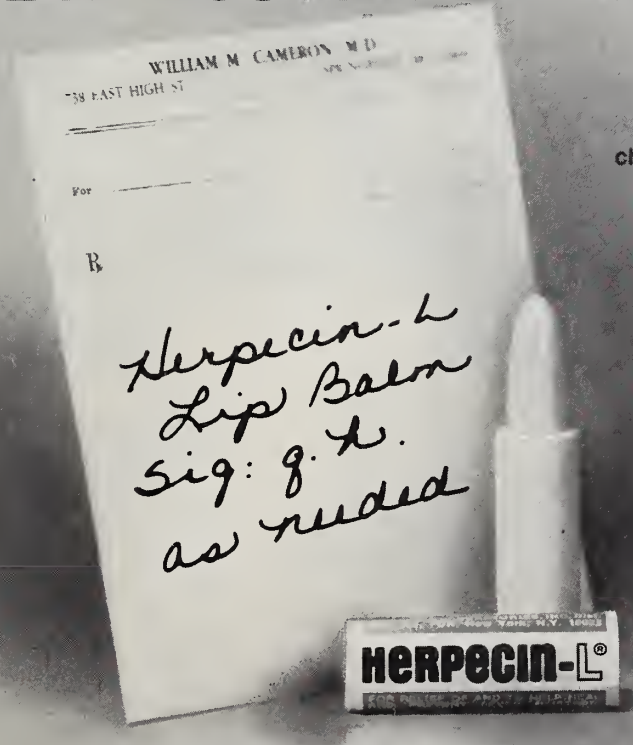
- Approved the following physicians as recipients of the 1983 ISMS Team Physician Award: Drs. K. J. Malmberg, Robert Hart, William Hart, William Schiffbauer, George Wilkins and Edward Grogg.
- Agreed to undertake a pilot project asking Trustees to call all 1982 members who do not renew in 1983.
- Authorized three panels (Downstate, Collar Counties and Cook) for the purposes of exploring reasons why physicians and students do or do not join ISMS.
- Directed that an ISMS membership benefits slide presentation be produced, to include elements for promotion of membership, including the American Medical Association and county medical societies.
- Approved in concept a proposal for a pilot program of personal learning plans as alternatives to mandatory CME; and directed that a meeting be arranged between the Department of Registration and Education and ISMS to discuss this proposal.
- Endorsed emergency rules concerning physician licensure in Illinois as adopted by the Department of Registration & Education. These relate to the category of approved programs of instruction. ISMS will regularly review future decisions on approval of medical education programs affected by the rules.
- Directed that the Department of Registration & Education be informed of the ISMS position that notification by the Department to a physician being audited for CME credits, should be sent by certified mail.
- Approved a contract with a new printing company, W. A. Krueger, to handle printing of the *Illinois Medical Journal.*
- Authorized restructured activity relating to impartial medical evaluations provided to Illinois Courts and the Industrial Commission.
- Directed that the Society inform the Division of Alcoholism, Illinois Department of Mental Health and Developmental Disabilities, of objection to social model alcoholism treatment programs using mood-altering substances for the treatment of alcoholism and indicate that if the patient is deemed to require such medication, the patient should be referred for appropriate medical care.
- Approved development of a grant proposal incorporating impaired physician committees; programs for physician spouses, medical students and residents; investigation of an office for impaired professionals; and suporting materials, budgeted at $16,000, for submission to the Division of Alcoholism.
- Accepted Draft II of the Accreditation Council for Continuing Medical Education document, "Protocol for the Recognition of State Medical Societies to Accredit Intra-state Continuing Medical Education," as written; and directed that this be communicated to the ACCME and AMA.
- Agreed to support the Chicago Medical Society in its application for direct accreditation through ACCME; and directed that a letter be written so informing CMS.
- Referred back to the CME Accreditation Committee for further consideration a recommendation that the ICCME Board of Directors investigate the feasibility of hiring professional surveyors for an accreditation site team to conduct all accreditation surveys.
- Amended the Illinois rules on Types and Duration of Accreditation so that the Committee on CME Accreditation may grant a one-time "Provisional Accreditation (resurvey 2 years)" to a sponsor granted "Accreditation (resurvey 4 years)" on its previous application.
- Referred the Chicago Medical Society Study Council's resolution on tax credits for care donated in treatment of the indigent to the Executive Committee for consideration and referral for review to appropriate committees; and requested that the resolution be introduced by the Chicago Medical Society for consideration by the House of Delegates at its 1983 Annual Meeting.
- Directed that an invitation be extended to Dr. John Standard, the newly-appointed Medical Coordinator of the Medical Disciplinary Board, to attend the next Board of Trustees meeting.

NOMINATIONS AND APPOINTMENTS

Various nominations and appointments were approved or ratified in accord with actions by the Board and Councils and Committees. These were as follows:

- Nominated Drs. Donald Binz, Mattoon; Raymond Del Fava, Evanston; Robert Henkin, Downers Grove; Mack Hollowell, Charleston; Alan Stutz, Springfield and Robert Sumner, Harrisburg, to serve on the Department of Nuclear Safety Radiologic Technology Accreditation Board.
- Reappointed Dr. Peter Friedell, Chicago, as ISMS representative to the Illinois Cancer Council Board of Trustees.
- Nominated Drs. James F. Duesman, Moline and Joseph R. Kraft, Winnetka to the AMA Diagnostic and Therapeutic Technology Assesment Committee (DATTA).
- Nominated Dr. Robert C. Hamilton, Chicago, for appointment to the AMA Committee on Long Range Planning.
- Appointed Dr. Morris T. Friedell, Chicago, to the Third Party Payment Processes Committee.
- Nominated Drs. Robert P. Johnson, Springfield; Arthur R. Traugott, Urbana; Fred Z. White, Chillicothe and Cyril C. Wiggishoff, Chicago, for appointment to work groups of the AMA Health Policy agenda.
- Nominated Drs. Morris T. Friedell, Chicago; Robert P. Johnson, Springfield and Cyril C. Wiggishoff, Chicago, for appointment to the AMA Steering Committee of the new Section on Hospital Medical Staffs.
- Appointed Dr. L. Michael Newman, Evanston, to the Panel for Impaired Physicians.
- Nominated Dr. Lee Gladstone, Chicago, for an additional term on the IDPH Alcoholism Treatment Center Licensure Advisory Council.

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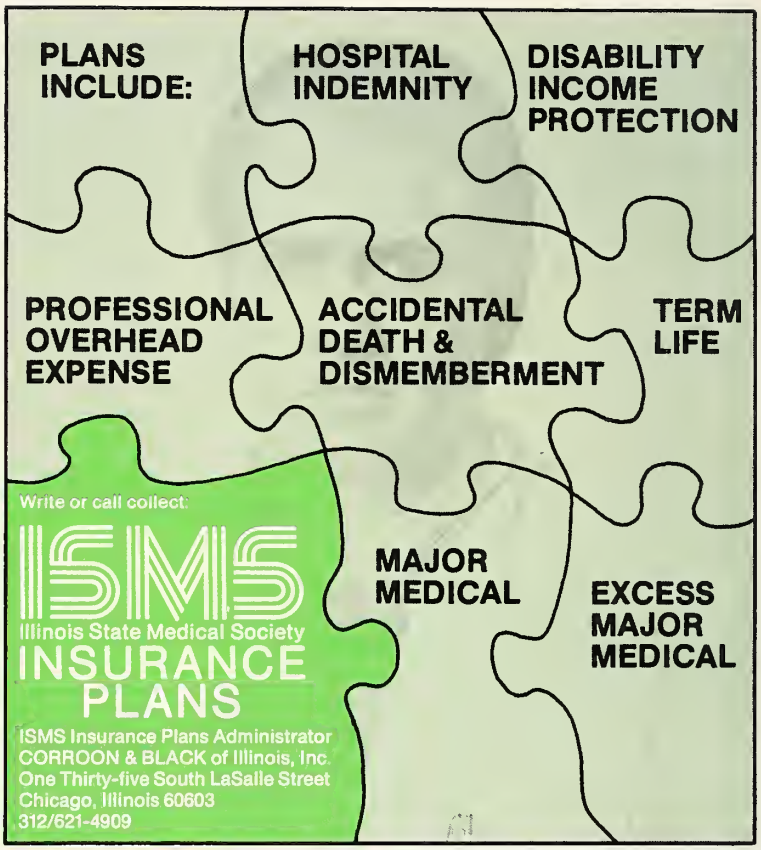
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President's Page



It's Not Business As Usual

In mid-February the leadership of the Illinois State Medical Society joined leaders from other states, counties and medical organizations in Chicago for the annual AMA National Leadership Conference. This event brought into focus the imperative nature of the need for us to have an "Agenda for Action." We all must recognize that there is an active restructuring of the medical care delivery system in the United States. The multiple benefits of the free enterprise system must be maintained in any quality delivery mode that is presented to our patients.

Newly emerging profiles of medicine which have become a reality include integration of hospital medical staffs into organized medicine, coping with competition and multiple alternate delivery systems. Critical analysis of these in light of the present high quality health care system will be an important point on this agenda.

There is ample evidence that we must deal with the realities of economic change going on in our present society. Truly, we must believe that it's not "business as usual." There are areas of prospective reimbursement to concern ourselves with, interacting with health care coalitions, establishing rational peer review organizations and dealing with a new alphabet of acronyms such as PPO, EPO, DRG, and the ubiquitous HMO.

Will our medical society be among those organizing for action? Will we be dealing with membership expansion, development of an American health policy agenda and production of informed leadership at all levels of the federation? I submit that these and many items form an agenda of issues about which we must have concern. The agenda for a concentrated effort at the county and state levels requires that we give all of the issues a long and hard look. ◀

Robert P. Johnson, M.D.

Robert P. Johnson, M.D., President



Thallium-201 perfusion scan showing left ventricle of patient with angina.



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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension; paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System*: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal*: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic*: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory*: bronchospasm. *Hematologic*: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous*: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings*: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

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—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-99).
—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).
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INJECTABLE
—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
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The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Kate A. Feinstein, M.D., Department of Radiology, Loyola University Medical Center, Maywood.

This 29-year-old man had a jejunoileal bypass for morbid obesity sixteen months ago. He has lost more than 100 pounds but has had general weakness, night sweats and fever for three weeks.



Figure 1
PA chest radiograph.

Your diagnosis?

(1) Hodgkin's Disease
(2) Sarcoidosis
(3) Metastases, seminoma
(4) Primary tuberculosis
(5) Mycoplasma pneumonia



Figure 2
Lateral chest radiograph, close-up of hilus.

(Continued on page 293)

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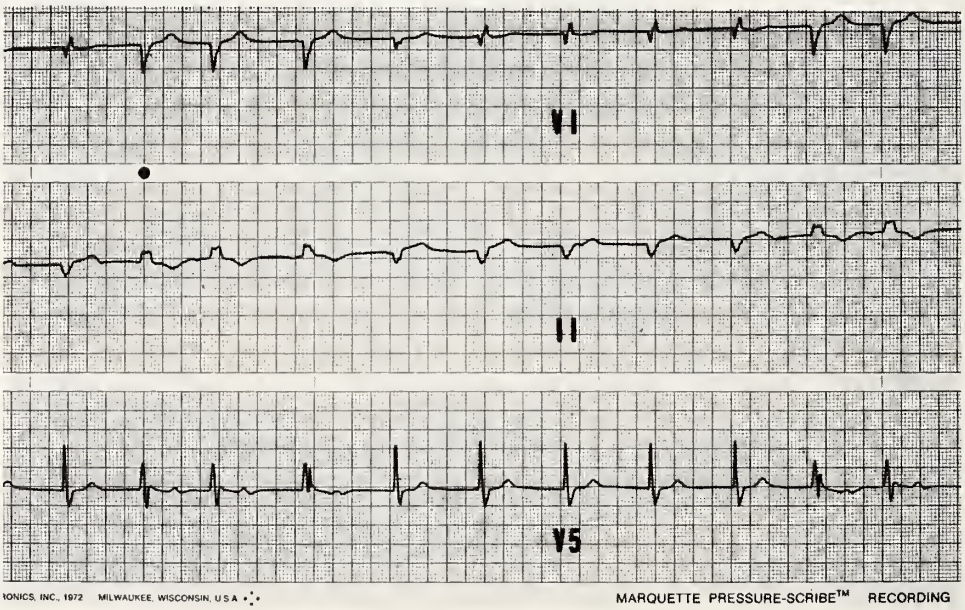
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EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Sconlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a sixty-one year old man who suddenly developed a severe retrosternal squeezing chest pain and came to the emergency service. The pain radiated down his left arm and was present for two hours when he arrived at the hospital. An acute inferior wall myocardial infarction was diagnosed. The highest creatinine kinase was 1400 units and a positive MB band was present. Moderate mitral insufficiency and congestive heart failure developed. His condition was stable for the next eight months. At this point he developed a pattern of unstable angina. A cardiac catheterization with angiography showed a left ventricular end diastolic pressure of 36mmHg. The left ventricular angiogram revealed inferior akinesis and anterior wall hypokinesis. The right coronary artery was 100% obstructed. The left anterior descending artery was 80% obstructed and provided collateral coronary circulation to the distal right coronary artery. The mitral regurgitation was now felt to be moderately severe. Heart surgery was recommended. The patient had a mitral valve replacement and a double aorto coronary saphenous vein bypass. Postoperatively, an irregularly slow rate with low cardiac index developed. This simultaneous lead V_1-II-V_5 rhythm strip was obtained:



Questions:

1. **The simultaneous lead V_1-II-V_5 rhythm strip shows:**
   A. New onset atrial fibrillation.
   B. Atrioventricular (AV) dissociation.
   C. Accelerated junctional rhythm with aberrant intraventricular conduction.
   D. Complete left bundle branch block.
   E. All of the above.

2. **Appropriate treatment might include:**
   A. An increase in digitalis for the low cardiac index.
   B. Discontinue digitalis.
   C. Start a dobutamine infusion.
   D. Consider a permanent demand pacemaker.
   E. Consider restudy, *i.e.*, another cardiac catheterization.

(Continued on page 288)

Pulse of the ISMS Auxiliary

Operation PSST

THE MEDICAL MARRIAGE

By Mrs. Don Hinderliter/ISMSA President

February was a month for multi-county and multi-state meetings. On February 9, DuPage, Kankakee and Will-Grundy counties met at the Joliet Country Club to discuss county leadership: where to find it and how to develop leaders after they have been found. Mrs. Torrence P. B. Payne, AMAA president, was the featured speaker. She discussed our "common bond" and our "common goal."

Like any other behavior, leadership is learned. Hearing from experienced leaders enables those less experienced to absorb, evaluate, and select a style of leadership.

On February 5, 12 and 26, multi-state meetings were held between Illinois/Wisconsin, (Rockford) Illinois/Iowa, (Moline) and Illinois/Missouri, (St. Louis). The two major topics for discussion were child abuse and the medical marriage. A film on emotional child abuse, "Because They Love Me," was shown, followed by a vigorous discussion. Emotional child abuse leaves no bruises or bodily scars, but it is as damaging as any form of physical abuse. The film showed that emotional abuse is cyclic, absent intervention into the family structure.

Dr. James McCoy, Dr. Eugene Vickery, Dr. Debra Shatoff and Linda Carpenter presented programs on the medical marriage in Rockford, Moline and St. Louis respectively. Data have indicated that the rate of divorce among physicians is lower than the national average.

A study done by a physician's wife and reported in the Journal of the Florida Medical Association describes the results of a questionnaire sent to medical society members' wives. Of this group, 95% stated that they felt neglected and over 50% felt that medical marriages were demanding and difficult for both wife and children. Sixty-five percent reported that some family member had received professional counseling and 17% said they had been physically struck by their husbands. Although these examples do not constitute scientific data, they do suggest the tip of an iceberg. Some wives also indicated that they felt they had raised their children primarily by themselves and that their lives were often lonely and unsatisfying.

There are also lots of positive aspects to the medical marriage. Children can be educated for the most part without worry. There is time to do volunteer work if you so choose.

Clearly, physicians' spouses do need a sounding board within the medical community. It assures the spouse of somewhere to release built-up tension and it also reassures her/him that she/he is not alone. If the spouse has a problem, chances are someone else also has had the same problem and can help them through it. Sometimes just saying it is enough. Knowing another spouse cares often helps. Just talking about it can be cathartic.

This is one reason for the program on medical marriage. We have begun a network of support in Illinois. We must see that it continues. ◀

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INDERAL provides treatment for coexisting angina pectoris or cardiac arrhythmias in addition to reducing blood pressure—for comprehensive protection. What's more, INDERAL is well tolerated, acting with few of the distressing side effects of antihypertensive agents such as methyldopa or reserpine. Impotence, depression, sedation, orthostatic hypotension, and nasal stuffiness are rare. (Please see following page for Brief Summary of Prescribing Information, including side effects of INDERAL.)

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References: 1. Traub, Y. M., *et al.*: Clin. Pharmacol. Ther. *28*:765 (Dec.) 1980. 2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. *647* (Suppl.):67, 1981. 3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
Inderal® (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System:* lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

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TABLETS

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—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-99).

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INJECTABLE

—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

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Obituaries

***Barringer, Donald M.,** Springfield, died January 19, 1983 at the age of 70. Dr. Barringer was a 1939 graduate of the Loyola University Stritch School of Medicine.

***Becker, William,** Lincolnwood, died February 21 at the age of 65. Dr. Becker was a 1945 graduate of the University of Health Sciences/Chicago Medical School.

***Brickman, Edward A.,** St. Petersburg, Florida, died January 13, 1983 at the age of 73. Dr. Brickman was a 1940 graduate of the Loyola University Stritch School of Medicine.

***Dunn, Richard F.,** Aurora, died February 1, 1983 at the age of 64. Dr. Dunn was a 1943 graduate of the Loyola University Stritch School of Medicine.

****Eckstein, Alfred,** Chicago, died January 14, 1983 at the age of 77. Dr. Eckstein was a 1932 graduate of *Deutsche Universitat Medizinische Fakultat,* Praha, Czechoslovakia.

***Escalona, Amaury S.,** Stamford, Connecticut, died November 12, 1982 at the age of 72. Dr. Escalona was a 1938 graduate of *Facultad de Medicina de la Universidad de la Habana,* Havana, Cuba.

****Gabriel, Carson K.,** Quincy, died January 29, 1983 at the age of 88. Dr. Gabriel was a 1920 graduate of the University of Illinois College of Medicine, Chicago.

****Gallagher, William J.,** Kankakee, died February 21, 1983 at the age of 89. Dr. Gallagher was a 1921 graduate of Rush Medical College, Chicago.

****Grove, Jacob S.,** Northbrook, died February 24, 1983 at the age of 83. Dr. Grove was a 1924 graduate of the Northwestern University Medical School, Chicago.

****Harris, Ellis H.,** Tucson, Arizona, died January 21, 1983 at the age of 75. Dr. Harris was a 1932 graduate of the University of Minnesota Medical School, Minneapolis.

***Harrod, John P.,** Chicago, died February 26, 1983 at the age of 59. Dr. Harrod, president-elect of the Chicago Medical Society, was a 1946 graduate of the Medical College of Georgia, Augusta. Dr. Harrod, an obstetrician-gynecologist, was an associate clinical professor at the University of Illinois and chairman of the department of obstetrics-gynecology at South Chicago Community Hospital.

Hook, Walter E., Chicago, died February 21, 1983 at the age of 74. Dr. Hook was a 1935 graduate of the Northwestern University Medical School, Chicago.

****Jacobson, Edmund,** Chicago, died January 7, 1983 at the age of 94. Dr. Jacobson was a 1915 graduate of Rush Medical College. A pioneer physiologist who specialized in tension control, Dr. Jacobson was known for his research and writing on progressive relaxation.

***Kanlins, Albert V.,** Chicago, died December 14, 1982 at the age of 74. Dr. Kanlins was a 1949 graduate of *Universitat Medizinische Fakultat der Phillipps,* Marburg, Lahn, Hessen, Germany.

****Kernwein, Graham A.,** Rockford, died January 25, 1983 at the age of 78. Dr. Kernwein was a 1931 graduate of the University of Chicago Pritzker School of Medicine.

***Knock, Frances E.,** died January 14, 1983 at the age of 61. Dr. Knock was a 1954 graduate of the University of Illinois College of Medicine, Chicago.

***Levitin, Elizabeth M.,** died February 2, 1983 at the age of 77. Dr. Levitin was a 1938 graduate of the Northwestern University Medical School, Chicago.

***McElroy, Robert E.,** Elmhurst, died December 22, 1982 at the age of 58. Dr. McElroy was a 1951 graduate of the University of Illinois College of Medicine, Chicago.

Millett, Henry S., Locust, Grove, Virginia, died February 14, 1983 at the age of 77. Dr. Millett, a former Highland Park psychiatrist, was a graduate of the University of Kansas.

**Parry, Norman G., Chicago, died February 23, 1983 at the age of 85. Dr. Parry was a 1923 graduate of the Northwestern University Medical School, Chicago.

**Riedel, J. A., Newport Beach, California, died February 12, 1983 at the age of 99. Dr. Riedel was a 1907 graduate from the Hahnemann Medical College and Hospital, Chicago.

*Rodkinson, B. L., Florida, died February, 1983, at the age of 72. Dr. Rodkinson was a 1936 graduate of the *Medizinische Fakultat der Universitat Bern,* Bern, Switzerland.

**Trapp, Harold J., Sycamore, died January 22, 1983 at the age of 76. Dr. Trapp was a 1933 graduate of the Loyola University Stritch School of Medicine, Maywood.

**Walsh, James A., St. Louis, Missouri, died January 18, 1983 at the age of 76. Dr. Walsh was a 1932 graduate of the Northwestern University Medical School, Chicago.

*Ward, Edward J., Peoria, died February 10, 1983 at the age of 68. Dr. Ward was a 1938 graduate of the St. Louis University School of Medicine, St. Louis.

*Zimmerman, Lazar E., Elgin, died February 14, 1983 at the age of 71. Dr. Zimmerman was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

**Zurfli, Clarence J., Chicago, died February 15, 1983 at the age of 76. Dr. Zurfli was a 1931 graduate of the Loyola University Stritch School of Medicine, Maywood.

**Indicates ISMS member.*
***Indicates member of Fifty Year Club.*

Correction—The March *IMJ* obituaries incorrectly stated that Julian Berman, M.D., of North Chicago, graduated from the Hahnemann Medical College and Hospital, Chicago. Dr. Berman, who died December 4, 1982, graduated from the University of Minnesota Medical School, Minneapolis. The editors apologize for this error.

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

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- ✓ Active loss prevention education effort

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Population 7,000, County—17,000. Hospital looking to recruit three physicians for primary care solo and/or group practice. Twenty-Five miles from Carbondale and the SIU-Medical School. Financial assistance negotiable. Hospital office suites available soon for physicians' practice. Contact: Ken Simpson, 517 N. Main, Anna 62906 618-833-5155. (5)

DANVILLE: Family Physicians desiring independent practice near a larger community with two hospitals and wanting the security of start-up support with guarantees. Call N. L. Saxton, M.D. (217) 443-5204 or send curriculum vitae to 812 North Logan Avenue, Danville, 61832. (4)

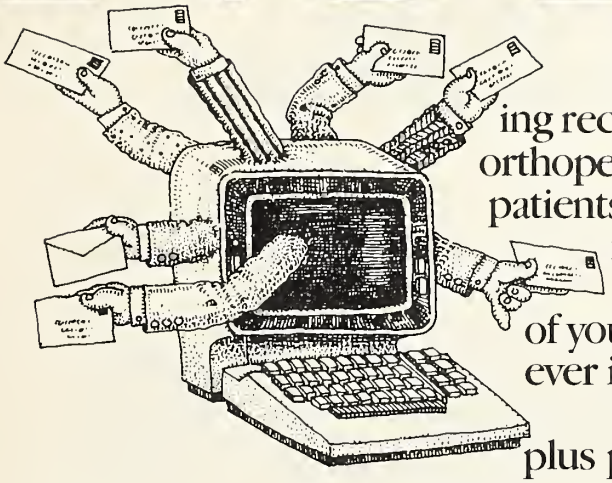
GIBSON CITY: Cardiologist, Internist wanted to join expanding multi-specialty medical staff associated with modern well equipped hospital; ICU capable of invasive monitoring; attached privately funded SNF; new professional office space available; rural community in east central Illinois within 30 minutes of major universities, tertiary care centers, metropolitan areas with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City, 60936 (217/784-4251). (7)

GLEN ELLYN: Physicians wanted to staff urgent care and industrial medicine facility in private practice in western suburbs of Chicago. Hourly base plus incentive package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, S. C., 454 Pennsylvania Ave., Glen Ellyn 60137. 312-469-9200. (5)

GLEN ELLYN: Physicians wanted—internist and family physician to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. CONTACT: Dave Bauer, Adm., Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave., Glen Ellyn 60137 (312-469-9200). (5)

SAYBROOK: Family practitioner—Excellent opportunity in East Central Illinois; large modern office available due to recent physician retirement; rural setting near modern well equipped community hospital; also within twenty minutes of major university tertiary care center, metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact: William Stack, Saybrook 61770. (309) 475-3521. (5)

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Medical Student Section in Action

National Meeting Highlights

By Pat Merrill, Governing Council Member and Alternate Delegate

Students from across the United States assembled in Miami Beach for the AMA-MSS meeting, Dec. 5-8, to discuss contemporary issues affecting medical students and other topics on which medical students can provide unique and valuable perspectives to the AMA house of delegates.

The business portion of the meeting centered around more than 30 resolutions submitted to the MSS house, several council reports and perhaps most importantly, six reports written and researched by individual medical students for the AMA's three year, multimillion dollar study designed to shape the course of American health care for the next several decades. Work was the order of the day, but other activities were enjoyed by the participants after hours, including a reception sponsored jointly by the University of Miami Medical School, the RPS, and the MSS.

Stimulating argument and testimony was heard on most of the resolutions presented, and the house adopted several policies that will affect and assist medical students as well as the public. Loans and other financial considerations were discussed extensively at the meeting. The assembly approved resolutions which: (1) support the continuation of current HEAL (Health Education Assistance Loan) loan levels; (2) promote study of the feasibility of direct loans from physicians to students; (3) oppose limitations to GSL's and (4) support dissemination of loan refinancing information to fourth year medical students.

Other resolutions supported by the assembly included opposition to HHS contraceptive regulations and requests for physicians to consider providing confidential family planning counseling and contraceptives to minors. The assembly also asked the AMA to develop legislation on abuse of the elderly and to have local medical society representatives talk to medical students about physician impairment.

One of the council reports asked that state societies redirect some of the AMA-ERF funds to financial aid programs for students. Another report requested an AMA investigation of the HPSL (Health Profession Student Loans) default rate data compiled by the GAO earlier.

By and large, the measure of success is whether the AMA decides to act on the students' requests, and the Miami Beach meeting was a considerable success by that yardstick.

Provocative thoughts and pertinent arguments characterized discussion of the policy papers for the HPAAP (Health Policy Agenda for the American People). Items of interest included assembly support for: (1) the concept of a consumer choice model of health care delivery; (2) mechanisms to implement education in preventive medicine and other health care issues; (3) formation of ad hoc and standing committees to facilitate ethical decision making; (4) endorsement of a prospective reimbursement system to reduce costs and (5) a commitment to governmental biomedical research with provisions to protect the public interest if private industry should capitalize on what public monies have funded.

Overall the meeting accomplished several tasks. It brought together medical students from throughout the country to learn of other perspectives, to exchange ideas, and to meet new people. Certainly, the participants will look forward to the annual meeting in Chicago this June for more discussion and lobbying in pursuit of excellence for medical education and practice.

Illinois Society, American Association of Medical Assistants

The Why and How of Certification

By Janet Binkowski, RN
President, Illinois Society, AAMA

CMA means Certified Medical Assistant, a title earned by a medical assistant who has passed the examination administered twice a year by the certifying board of the American Association of Medical Assistants. The examination covers both the administrative and clinical areas of medical assisting.

The certification program promotes high standards. Many medical assistants who do a good job and are concerned about quality performance feel the lower standards often accepted today are decreasing their professional credibility and detracting from the image of a competent medical assistant. The certification process can open up new areas of understanding, knowledge and challenge for the medical assistant who is willing to take the risk of matching her expertise against a set of standards of competency. It may offer job enrichment, job promotion and job security. Personally, it offers opportunity for self discipline, self assurance and professional competence. The title of certified medical assistant indicates ability to perform certain tasks and assume responsibility for a number of related procedures. The CMA is no longer an unknown quantity of unknown quality and is assumed to be capable of performing medical assisting duties.

The test is not primarily a "book" exam but has been designed to measure areas familiar from job experience. However, because medical assisting jobs vary greatly, the examination must include areas consistently present and also unfamiliar areas. There is no set plan for success but personal study habits and available time for exam preparation should be considered. Interested persons may contact the AAMA office, 20 North Wacker Drive, Suite 1575, Chicago, IL 60606, 312-899-1500 for information regarding application forms, test dates and study outlines to prepare for the examination.

Independent Study

Students should examine the study outline, get an overview of the work ahead and note topics which will require more intensive review. Set up a study schedule and stick to it, choose reference books and set up a permanent study area. Make a notebook with divisions for the various areas being studied, keeping clear and concise notes. Adhere to your study program.

Group Study

Students should schedule meetings regularly according to the group's wishes, organize a curriculum and promote participation of all members. Solicit outside help from those who have passed the exam, community college resources or instructors.

Whatever route you take, start now. Preparation for the examination requires time, dedicated effort, and the realization that it can be done.

For further information regarding certification or Illinois Society, American Association of Medical Assistants, contact Janet Binkowski, RN, President, Illinois Society, 428 Adams Street, Dolton, IL 60419, or Ruby Jackson, CMA, Chairman, Public Relations Committee, 7337 South Shore Drive, #625, Chicago, IL 60649. ◀

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Intracoronary Nitroglycerine Infusion Therapy

Coronary Artery Spasm Causing Myocardial Infarction

By H. Weston Moses, M.D., George J. Taylor, M.D., Ziad Asali, M.D. and Thomas E. Brewer, M.D./Springfield and Taylorville

A 30-year-old man presented with acute, anterior myocardial infarction and total occlusion of the proximal left anterior descending artery. Intracoronary bolus injection of nitroglycerine resulted in transient opening with a proximal filling defect suggesting intracoronary thrombus. Streptokinase was infused into the coronary artery but recurrent spasm apparently caused reocclusion. Continuous infusion of nitroglycerine and streptokinase in the coronary artery was effective in maintaining patency. Follow-up angiography demonstrated a coronary artery which appeared to be normal. Continuous intracoronary infusion of nitroglycerine should be considered for resistant coronary spasm.

Coronary artery spasm has a pathogenic role in acute myocardial infarction (AMI) among patients with coronary atherosclerosis.[1,2] When acute myocardial infarction occurs in patients with normal coronary arteries, the pathophysiology of ischemia is assumed to be spasm.[3-7] Platelet aggregation followed by lysis and recanalization is another possible cause of transient coronary occlusion. It is possible that thrombosis and spasm interact.

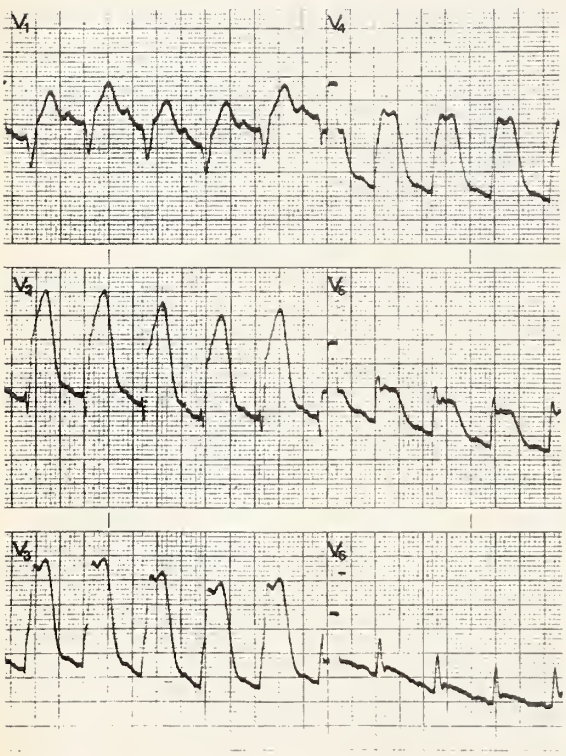


Figure 1
ECG leads V1-4 at admission showing ST segment elevation.



Figure 2
Initial left coronary angiogram showing total occlusion of the anterior descending artery (arrow).



Figure 3
Left coronary angiogram after intracoronary nitroglycerine. The anterior descending artery is patent but there is a filling defect proximally (arrow).

We report a young patient who had angiography during acute anterior infarction. He had spasm of a normal appearing anterior descending artery with thrombus formation at the site of spasm. Spasm responded to intracoronary but not to intravenous nitroglycerine (NTG), and both nitroglycerine and streptokinase infusion into the left coronary artery were needed to maintain patency.

A 30-year-old white man with no prior history of chest pain and no risk factors for coronary heart disease was first seen within one hour of the onset of chest pain. The initial electrocardiogram (ECG) had 1mm ST segment elevation in anterior precordial leads. Pain worsened in intensity and a second electrocardiogram showed 12mm ST segment elevation in leads 1-4 (Figure 1). Sublingual nitroglycerine (NTG) was given without effect on ST segment elevation. Ten minutes later he had ventricular fibrillation requiring DC cardioversion. Lidocaine therapy was initiated, and after a short period of stabilization he was transferred to our hospital for intracoronary thrombolytic therapy.

Cardiac catheterization was begun 2.5 hours after the onset of chest pain. Using the Seldinger technique a 7F pigtail catheter was inserted into the right femoral artery and advanced to the left ventricle. The end-diastolic pressure was 35mmHg. A right anterior oblique angiogram showed akinesis of the entire anterior wall of the left ventricle. Judkins catheters were used to visualize first the right coronary artery which was normal, and then the left coronary artery. The left anterior descending (LAD) coronary artery was totally occluded on the initial visualization (Figure 2).

A bolus injection of nitroglycerine, 200mcg, was given into the left coronary artery. Angiography was repeated and there was partial opening of the left anterior descending but sluggish distal flow. A filling defect in the proximal portion of

the vessel suggested coronary thrombus (Figure 3). For this reason, 10,000 units of streptokinase was given through the left coronary catheter as a bolus injection and a 3,000 unit/min. infusion begun. Fifteen minutes later, contrast was injected into the left anterior descending and it was found to be totally occluded. Nitroglycerine 200 mcg was again injected through the coronary catheter. Within two minutes the patient had ventricular fibrillation requiring DC cardioversion. Bretyllium tosylate 600mg was administered and a 2mg/min. bretyllium infusion was added to the 3mg/min. lidocaine infusion. Intravenous infusion of nitroglycerine, 200mcg/min. was started. Re-injection of the left anterior descending showed restoration of flow to the distal vessel. However, there was a persistant filling defect at the site of occlusion. Because of its asymmetry, this suggested thrombus, and streptokinase infusion was continued. Ten minutes later angiography was repeated and again the artery was occluded despite intravenous nitroglycerine therapy. Intracoronary nitroglycerine 150 mcg was administered through the coronary catheter, ventricular fibrillation followed and the coronary artery was found to be open.

Apparently, recurrent spasm of the proximal left anterior descending occurred despite peripheral intravenous nitroglycerine therapy. For this reason, nitroglycerine was infused directly into the left coronary artery at a rate of 100mcg/min. together with streptokinase 3,000 unit/min. This combination infusion was continued for 30 minutes. During this time the patient was treated with nifedipine 20mg sublingually and the peripheral nitroglycerine infusion was continued. At the onset of intracoronary nitroglycerine therapy, chest pain and ST segment elevation resolved. There was no further arrhythmia. The left anterior descending remained patent following the intracoronary infusion and there was a reduction in the size of the filling defect in the proximal portion of the artery. Apparent spasm in the distal artery also resolved.

The patient was subsequently treated with nifedipine 40mg/day and intravenous heparin. He developed electrocardiogram evidence for anterior wall myocardial infarction and serum creatine kinase measured at four hour intervals rose to a peak of 2,800 units (normal less than 220) 12 hours after admission.

Two days following acute myocardial infarction the patient had repeat coronary arteriogram which showed a normal appearing left anterior descending coronary artery (Figure 4). A gated cardiac blood pool scan done 12 hours after admission showed a left ventricular ejection fraction of 33% with anterior wall akinesis. A repeat scan done 10 days later showed left ventricular ejection fraction of 51% and return of contractility to the anterior wall; the apex remained akinetic.

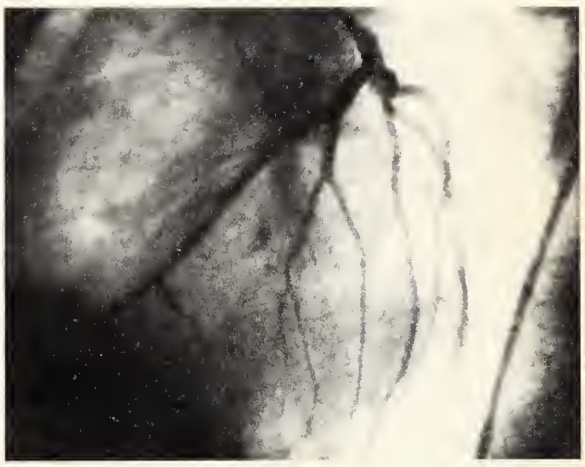


Figure 4
Left coronary angiogram six weeks after MI with an apparently normal proximal anterior descending artery.

He was discharged from the hospital on nifedipine therapy. Six weeks later he was re-admitted and angiography repeated. The anterior descending artery appeared normal. Ergonovine maleate was given in sequential doses of 0.05mg, 0.1mg and 0.2mg intravenously. There was no evidence of coronary artery spasm during ergonovine infusion with the patient on long acting nitrates and nifedipine. A left ventricular angiogram showed akinesis of the left ventricular apex with normal contractility of the proximal and mid-anterior wall.

Discussion

This 30-year-old man with myocardial infarction had unequivocal spasm and total occlusion of the anterior descending coronary artery responsive only to continuous intracoronary infusion of nitroglycerine. A filling defect was noted at the site of occlusion following nitroglycerine therapy consistent with thrombus. Filling defect size diminished after local streptokinase infusion and two days later the artery looked normal.

Coronary artery spasm in the absence of atherosclerosis is a known cause of angina pectoris, serious arrhythmia and sudden death. Finding angiographically normal arteries in patients with prior myocardial infarctions suggest spasm as a mechanism for myocardial infarction.[3-8] Another

potential pathogenesis of acute myocardial infarction in such patients is platelet aggregation and thrombus formation with subsequent lysis of thrombus. Since angiography has rarely been performed during the acute phase of acute myocardial infarction, proof of the mechanism of coronary occlusion in these patients with normal coronary arteries has been lacking.

Intervention angiography has provided an opportunity to study the relative roles of spasm and thrombus formation to the pathogenesis of acute myocardial infarction. Intracoronary nitroglycerine may result in opening of the occluded artery in 10-40% of patients with acute infarction,[1,9] but these patients have also had an atherosclerotic lesion at the site of spasm. Our patient represents one end of the clinical spectrum, pure spasm in a normal appearing artery. It also demonstrates an interaction of spasm and thrombosis in pathogenesis of myocardial infarction among patients with normal coronary arteries.[12]

Our patient also had ventricular fibrillation with reperfusion. Although ventricular arrhythmias have been observed in patients receiving thrombolytic therapy for acute myocardial infarction, fibrillation has not been common.[8-10] Patients with coronary spasm and variant angina are at risk for sudden death. It is possible that our patient's unusually severe dysarrhythmia was related to spasm and then reperfusion.

Although spasm responded initially to intracoronary nitroglycerine, it recurred despite continuous, intravenous nitroglycerine infusion. Failure of coronary artery spasm to respond to systemic nitroglycerine has been documented both when coronary artery spasm is ergonovine-evoked and when it occurs spontaneously.[11] Our patient required continuous intracoronary infusion of nitroglycerine to maintain patency of the anterior descending artery, which indicates unusually severe spasm. This therapy should be considered in the face of resistant spasm with myocardial infarction. This patient may also be the best documented case to date of acute myocardial infarction with normal coronary arteries, providing insight into the potential interplay of spasm and thrombosis in the pathogenesis of acute myocardial infarction.

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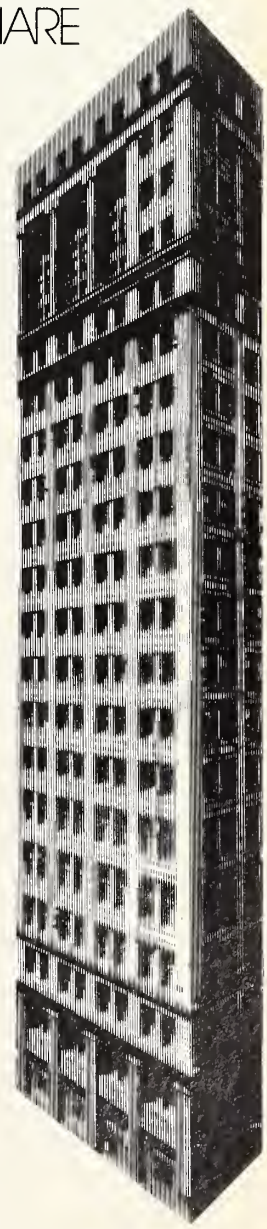
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Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR., M.D., CONTRIBUTING EDITORS

Surgical Grand Rounds are held weekly on Tuesday, 5:00 PM in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital from the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 19, 1982.

Intestinal Angina

Chronic Mesenteric Ischemia

Dr. Joseph Casey: The patient is a 64 year old woman who presented with a two to three week history of aching pain and coolness in her left foot and lower leg. These complaints were present at rest and exacerbated by walking. She was admitted for evaluation of lower extremity arterial occlusive disease. Her past history included a left-sided transient ischemic attack two years prior to admission and a presumed myocardial infarction in 1972. She also had mitral valve prolapse documented by echocardiography.

A review of her systems was essentially negative except for what she called a spastic colon. She complained of chronic constipation, weight loss and abdominal cramps for which she took stool softeners. Her medications included levothyroxine sodium, phenytoin sodium, dipyridamole, sodium pentobarbital, docusate sodium and diazepam. She had no allergies.

Physical examination revealed a thin woman who appeared chronically ill. She was afebrile with blood pressure of 120/70 and a pulse which was 65 and regular. Her height was 5'2", her weight was 44.5kg or 98 pounds. Her head and neck examination was normal, her chest was clear and her breasts had no masses. Heart examination revealed a mid-systolic click and murmur at the apex. Her abdomen was scaphoid, non-tender and no masses were felt. There was a systolic bruit over the mid-abdomen. The carotids were palpable and no bruits were heard. Bilateral femoral bruits were present. The lower extremity pulses were normal except for absent left pedal pulses. Doppler flow indices were approximately 1.0 for all pedal pulses. CBC, SMA-20 and urinalysis were unremarkable. An EKG was normal. The patient underwent arteriography.

Dr. Robert Vogelsang, Angiography was performed on this patient basically for peripheral vascular disease. The peripheral examination was within normal limits, with the exception of two instead of three vessel run-off to the left foot. We were surprised, however, to find multiple visceral artery occlusions. There was occlusion of the proximal celiac and superior mesenteric arteries (SMA). The only visceral artery visualized was the inferior mesenteric artery (IMA) which comes off at the aorta of L3. (Figure 1) There was marked stenosis at its origin with marked post stenotic dilatation.

On later films in the series, we noted collateral filling of the celiac and SMA via the IMA and its collateral branches, particularly the left celiac and marginal artery. (Figure 2) Confirmation of these findings was obtained with lateral aortography. At the origins of the celiac and superior mesenteric arteries we see essentially no flow (Figure 3).

Dr. Joseph Casey: These X-rays shifted the

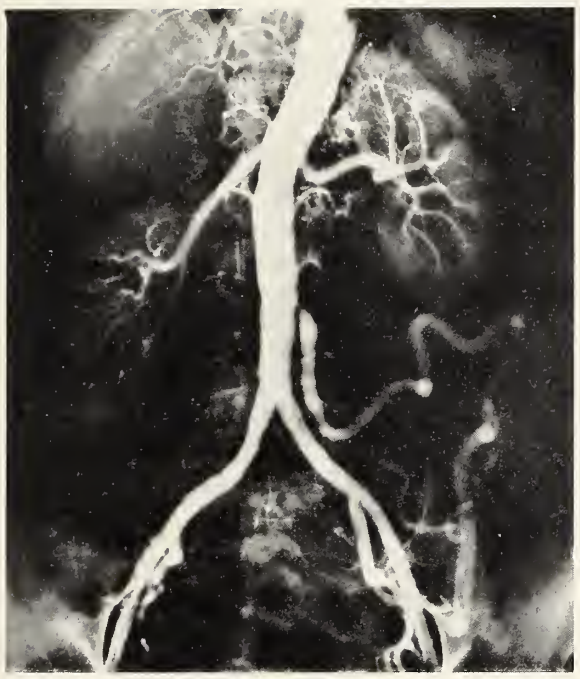


Figure 1.
Ninety-five percent stenosis of inferior mesenteric artery. Celiac and superior mesenteric arteries are not visualized.



Figure 2.
The large meandering mesenteric artery fills the superior mesenteric artery via the left colic and middle colic arteries.

emphasis on the patient and we then reviewed her history. The patient presented the identical history when she was asked to amplify her complaints. It was only with specific questioning and the aid of her husband that several new facts were added.

First, she no longer enjoyed eating and the size and number of her meals had diminished. She experienced abdominal pain after meals and would try to move her bowels to relieve this pain. When she got no results, she considered herself constipated. Although she could not recall any weight loss, because she had always been thin, she did admit that her clothes had become too large. She also remembered losing weight in 1972 after the episode of subxiphoid pain which had been diagnosed as a coronary occlusion.

Based on the revised history and the arteriogram, we recommended that the patient undergo mesenteric revascularization. The patient was taken to the operating room and underwent celiac and superior mesenteric artery bypasses with autogenous saphenous vein and reimplantation of the inferior mesenteric artery. Bilateral lumbar sympathectomy was performed because of the symptomatic vasospastic disease in her feet.

The postoperative course was without significant problems. She is currently three months postoperative, and I understand she still has some minor vague abdominal complaints, mostly with regard to persistent constipation. She has an excellent appetite and has gained five pounds.

For further discussion of this case, I introduce Dr. Linda Graham, vascular fellow.

Dr. Linda Graham: Mesenteric ischemia can be categorized into three groups: acute, non-occlusive or low flow ischemia, and chronic ischemia. Acute mesenteric ischemia can be a result of either embolization or thrombosis of chronically diseased vessels. This latter situation, thrombosis of chronically diseased vessels, occurs in one-third to one-half of patients who present with acute intestinal ischemia.

Chronic mesenteric ischemia is the topic of today's discussion. Atherosclerosis accounts for approximately 90% of all cases of chronic intes-



Figure 3.
Lateral view of the abdominal aorta shows occlusion of the celiac and superior mesenteric arteries at their origin. This is typical of atherosclerotic occlusions.

tinal ischemia. Fibromuscular dysplasia has also been reported as a cause of chronic intestinal ischemia. Other causes include arteritis of various etiologies: systemic lupus erythematosus, rheumatoid vasculitis, Takayasu's aortitis with splanchnic artery involvement, allergic vasculitis, and vasculitis following aortic coarctation resections. Congenital abnormalities of the visceral vessels and neurofibromatosis have also been cited as causes of intestinal ischemia. A more controversial etiology is that of celiac entrapment syndrome, where a fibrous band occludes or causes a stenosis of the proximal celiac artery. Certainly the anatomic abnormality is much more common than the clinical entity.

The entity of intestinal angina due to splanchnic atherosclerosis has been recognized only relatively recently. During the early 1900's, there was much discussion as to whether or not vascular disease could cause abdominal pain. Physicians as prominent as Sir William Osler thought that abdominal pain was really a manifestation of cardiac disease and not of intestinal vascular disease. In 1936, Dunphy reported on intestinal angina after he had reviewed the hospital records of patients presenting with intestinal infarction. He found that seven of 12 of these patients had had previous symptoms of abdominal pain. He concluded that "vascular disease of the mesentery can cause abdominal pain in the absence of gangrene or peritoneal irritation. It is suggested that the pain so caused is the result of an anoxemia of the intestinal musculature." He suggested that the clinical importance of this was that it was a precursor to fatal mesenteric infarction.

It was not until 1957 that Mikkelsen, in discussing intestinal angina due to splanchnic atherosclerosis, suggested that "whereas medical measures were of no benefit in preventing the unrelenting progression of the disease, the potential for surgical correction does exist." Just one year later, in 1958, the first successful mesenteric revascularization was reported by Shaw and Maynard.

Although mesenteric atherosclerosis is common, mesenteric angina is distinctly uncommon. The widespread occurence of splanchnic atherosclerosis has been documented in several autopsy series. Usually the proximal five to 15mm of the celiac, SMA, or IMA is involved. The reported incidence of splanchnic atherosclerosis in unselected autopsy series ranges from 35% to 70%. While mild stenoses are common, "critical" stenoses are distintly uncommon, occuring in 3% of celiac arteries, 5% of superior mesenteric arteries, and 11% of inferior mesenteric arteries examined in autopsy series. Furthermore, in these series, correlation between degree of the stenosis and the previous history of GI symptoms was not found.

The reason for the rarity of intestinal angina, despite the frequency of mesenteric atherosclerosis, lies in the rich collateral vasculature in the mesentery. Collaterals between the celiac axis and the superior mesenteric artery exist in the pancreatic and gastroduodenal arteries. Branches of the middle colic join with branches of the left colic to provide collateral between the SMA and the IMA.

With stenosis or occlusion of the celiac and superior mesenteric arteries, the IMA may serve as the most important source of blood for the intestine. The major collateral is in the central portion of the mesentery, the central anastomotic artery. This has variously been called the arc of Riolan, the meandering mesenteric artery, the artery of Gonzalez, or the artery of Moskowitz. A second collateral is the more peripherally located marginal artery of Drummond. This is a much

less important collateral.

Usually at least two of the three mesenteric vessels need to be severely diseased before a patient has symptoms. However, obstruction of two or all three vessels does not necessarily cause symptoms. Isolated chronic occlusion of the celiac, SMA, or IMA is almost never of clinical or surgical significance. An isolated lesion may assume significance when there has been or will be a surgical procedure which will interrupt the normal collateral pathways.

Unlike peripheral vascular disease, in mesenteric ischemia the females predominate, the female to male ratio being approximately 2:1. The patients range in age from about 30 to 80 years, the majority being over 60 years of age. There is a distinct group of younger patients in which the females definitely predominate. In patients over the age of 60, the male to female ratio is nearly equal. The reason for the affliction of the younger patients and the female predominance still remains unknown.

The presenting symptom of intestinal angina is almost always postprandial abdominal pain, which is dull and aching or colicky in nature. It typically begins 15-60 minutes after ingestion of a meal and lasts from one to four hours. Experimental evidence suggests that with the ingestion of food, mesenteric blood flow increases and peristalsis increases. Normally, the arterial inflow decreases during muscular contraction and then increases as the musculature relaxes. In intestinal angina with chronic occlusive disease, however, there is already a reduction in the perfusion pressure; thus with muscular contraction the blood flow is markedly decreased. Furthermore, the response of the intestine to ischemia is contraction. The food intake initiates a vicious cycle of increased peristalsis, decreased blood flow and then increasingly severe intestinal contractions which results in spasm. This may be the etiology of the abdominal pain.

Because of the intimate association of pain with food ingestion, the patient limits his food intake, the so-called "small meal syndrome." Sometimes patients restrict their intake to liquids in an attempt to avoid the pain. With this voluntary restriction of food, weight loss results. In most cases, weight loss exceeds 10% of lean body mass. Not all patients have this typical abdominal pain, but the combination of pain and weight loss is so frequent that diagnosis of intestinal angina is almost excluded by its absence. Other symptoms include complaints of altered GI motility, with either diarrhea or constipation occuring in about 50% of patients. Less common symptoms are those of nausea and vomiting and diffuse abdominal complaints. Also, the patient often has symptoms suggestive of atherosclerotic occlusive disease in other parts of the body. Complaints of claudication or angina are common.

Physical findings may be limited to evidence of marked weight loss. An abdominal bruit is present in about 75% of patients, but it is a nonspecific finding. The absence of an abdominal bruit certainly does not eliminate the possibility of chronic mesenteric ischemia. There is a history of physical findings of hypertension or cardiac disease in about 40% of patients. About 25% of the patients will have symptoms of cerebrovascular disease. Aneurysmal disease or peripheral vascular occlusive disease occurs in about 50%. Diabetes is also frequent; essentially all patients have significant smoking histories.

The differential diagnosis includes almost all chronic intraabdominal diseases and malignancies. A history of excessive weight loss, even cachexia and abdominal pain, often leads to suspicion of malignancy, particularly gastric or pancreatic carcinoma. The symptoms of postprandial pain in middle-aged women also suggest the diagnosis of chronic cholecystitis. A chronic pancreatitis and peptic ulcer disease are also in the differential diagnosis. Sometimes because of the confusing symptoms of diarrhea and abdominal pain with normal GI studies, the patient will be diagnosed as having a malabsorption syndrome or irritable bowel syndrome.

The usual diagnostic studies initially undertaken are those which exclude the more common causes of abdominal pain. Blood chemistries, oral cholecystogram, upper GI, barium enema, and endoscopic studies are usually normal.

Clinically apparent malabsorption has been reported in sporadic cases of intestinal angina. Consequently, investigative tests of intestinal absorption have received a great deal of interest. D-xylose absorption and provocative d-xzylose studies, analysis of fecal fat, serum carotene levels, vitamin B12 absorption, and vitamin A tolerance have been evaluated, but have not proven to be of value in diagnosis or screening.

Diagnosis depends upon aortography, with demonstration of advanced splanchnic atherosclerotic occlusive disease. Standard AP views may be misleading in that these occlusive lesions are usually orificial lesions, which are not well-seen on the standard AP projection. A large central anastomotic artery, indicative of mesenteric artery occlusion, may be seen on AP view. However, lateral projection is essential to define the orificial lesions.

Although patients with intestinal angina gen-

erally have significant disease of two or three mesenteric vessels, occasionally occlusion of a single vessel, usually the celiac, has been reported to cause symptoms. Hollier tabulated the distribution of disease in patients with intestinal angina seen at the Mayo Clinic. Significant disease of all three vessels was seen in 41% of patients. Seventy-seven percent had at least two vessel involvement, the celiac and superior mesenteric arteries being involved more frequently.

Surgical intervention is indicated in symptomatic intestinal angina to relieve pain and allow weight gain. Operative intervention may also prevent mesenteric infarction. In the asymptomatic patient, revascularization may be necessary when standard aortic reconstruction would obliterate a patent IMA serving as a major collateral to the intestine, or in gastrointestinal surgery in which established collateral pathways will be interrupted. Operative procedures must be individualized according to the anatomic pattern and extent of disease and also the existing collaterals. It is well known that a single vessel revascularization can alleviate symptoms. However, if a single graft occludes in the early postoperative period, mesenteric infarction is common; and if a single graft occludes in the late postoperative period, recurrence of symptoms is very common. Consequently, multiple vessel reconstruction is favored.

The two basic methods of reconstruction are endarterectomy and bypass grafting. Both are effective. The choice is one of personal preference. Bypass grafting is generally regarded as a simpler procedure with easier exposure, particularly when concomitant aortic surgery for aneurysm of occlusive disease is required.

If bypass grafting is selected, either saphenous vein or prosthetic material can be used. Although saphenous vein is less thrombogenic, it does not have the clear advantage in mesenteric revascularization as it does in the peripheral vascular surgery. The relatively stiff prosthetic grafts have the advantage of being less likely to be deformed by shifts in intestinal position by postural changes.

Those experienced with visceral artery endarterectomy have good results with this technique. Usually a thoracoabdominal retroperitoneal approach is used with reflection of the abdominal viscera to the right. A trap-door aortotomy is then formed around the vessels involved. An endarterectomy of the aorta is performed with removal of the atherosclerotic lesions from the orifices of the vessels. With occlusion of the superior mesenteric artery there is often a tail of thrombus which extends to the level of the first major branch. Removal of this thrombus often requires a longitudinal arteriotomy which is then closed with a vein patch.

If bypass grafting is selected for the revascularization of the vessels, grafts may originate from the distal thoracic aorta, the infrarenal aorta or an aortic graft, or from the iliac vessels. The distal thoracic aorta is relatively spared from atherosclerotic changes and only grafts from the distal thoracic aorta have the advantage of antegrade flow. The disadvantage of use of the distal thoracic aorta is that a thoracoabdominal incision is usually required, which carries a higher morbidity in this elderly, debilitated group of patients. Furthermore, there has been no clear documentation of the disadvantage of the retrograde flow in grafts originating from the infrarenal aorta to the mesenteric vessels. Regardless of graft origin, a retroperitoneal position of the graft is essential. This provides stability to the graft and it will be less likely to be kinked with positional changes than free-floating intraperitoneal grafts.

If an anterior approach to the celiac is selected, one approaches the celiac axis by dividing the crura and clearing the tissue from the anterior surface of the aorta. After cross-clamping the aorta and removing a button of the aorta, a graft is sutured end-to-side to the thoracic aorta and end-to-end to the celiac axis.

For revascularization of both the celiac and superior mesenteric arteries, a similar approach is used and the pancreas is mobilized caudally. A bifurcated graft is anastomosed to the distal thoracic aorta with one limb sewn end-to-end to the celiac axis and the other end-to-end to the superior mesenteric artery.

For bypass via the anterior abdominal approach, one divides the posterior peritoneum over the aorta with mobilization of the duodenum. The infrarenal aorta is isolated. The celiac axis is then approached through the lesser sac and the branches are isolated. The graft is usually taken to either the splenic artery or the hepatic artery, because these are the larger and more easily approached branches. A tunnel is then created from the infrarenal abdominal aorta, beneath the pancreas, to the level of the celiac axis. Then the graft, either a vein or a prosthesis, is passed in that tunnel and anastomosed end-to-side to the hepatic or splenic artery and also to a convenient position to the infrarenal aorta.

The superior mesenteric artery is approached through the medial aspect of the mesentery. An area of the superior mesenteric artery proximal to its major branches is selected where the SMA is at a maximum size. An appropriate position

of the infrarenal abdominal aorta is also selected and a short interposition graft is anastomosed end-to-side to the superior mesenteric and also to the infrarenal abdominal aorta.

If aortic reconstruction is needed for aortoiliac occlusive disease, or for an aneurysmal disease, the aortic procedure is undertaken first with the mesenteric grafts attached to the aortic graft. The inferior mesenteric artery can be reimplanted if it is patent. Following aortic reconstruction for aneurysmal disease, a button of the aneurysm wall containing the IMA is removed and anastomosed to the graft.

The operative mortality for mesenteric revascularization is 5 to 10%, depending on the number of emergent situations in a given series. Emergency operation undertaken for acute thrombosis of a previously diseased vessel or of a previously placed graft increases mortality. Most deaths are a result either of bowel infarction or of cardiovascular disease. Of the patients who survive surgery, 90% have good results, with relief of pain and weight gain. The five year survival is 60 to 80%, depending upon concomitant cardiovascular disease.

The late recurrence of symptoms varies with the number of vessels revascularized. When only one of two or three vessels are revascularized, there is a 50% late recurrence of symptoms, according to Hollier. When two of the three diseased vessels are revascularized, the late recurrence rate drops to 29% and when all involved vessels are revascularized, the late recurrence rate drops to 11%. Hollier tried to correlate the late recurrence with the type of graft used, but the late occlusion rate is about 25% regardless of whether vein, PTFE, or Dacron is used.

In conclusion, splanchnic atherosclerosis is very common, but mesenteric intestinal angina is distinctly uncommon. It is unlikely to exist unless at least two of the three major mesenteric vessels are diseased. There is no effective screening test for intestinal angina. Consequently, the diagnosis relies on a typical history and arteriographic evidence of significant stenoses of two of the three major mesenteric vessels. Multiple vessel reconstruction is advocated in patients with classical symptoms, documented weight loss, and evidence of advanced splanchnic atherosclerosis. In these cases excellent results can be expected. ◀

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Case Reports

Pure Motor Hemiplegia Associated With Phenelzine Use

By Rita Shapiro, D.O. And José Biller, M.D./Maywood

A case of pure motor hemiplegia (PMH) in a 37-year-old previously healthy obese woman is described. She was found to have a small hematoma in the posterior limb of the internal capsule and basal ganglia on cranial computed tomography (CCT) scan. Although there was no history of hypertension, she was known to use the monoamine oxidase inhibitor (MAOI), phenelzine (Nardil®) and occasionally consume foods high in tyramine. During her outpatient follow-up, she was later found to have intermittent hypertension, believed related to her own resumption of phenelzine along with dietary indiscretions. She had also begun a high protein low calorie diet, the effects of which are unclear. Her atypical history is discussed in view of current concepts of pure motor hemiplegia.

A 37-year-old, right handed woman was admitted with a twelve hour history of headache and right sided weakness. At 6:00 p.m. the previous evening, she had developed severe bifrontal cephalgia which was not improved with aspirin. One hour later, she had developed a right-sided hemiparesis, most severe in her arm, with associated dysarthria. When her husband found her on the floor three hours after the first symptoms, she was awake but unable to rise or walk, even with assistance.

She improved overnight and was able to resume walking the next morning, when she entered the hospital. She reported no history of similar events. She had been taking phenelzine 60mg/day for depression. She denied arterial hypertension, diabetes mellitus, heart disease, or oral contraceptive use. She had smoked 1½ packs of cigarettes per day for seventeen years. Her past history was otherwise unremarkable except for a gastroplasty for obesity four months before, and past tubal ligation. Her family history was non-contributory.

On admission, her temperature

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Figure 1
CCT showing hemorrhage in medial aspect of the left globus pallidus and posterior limb of the internal capsule.

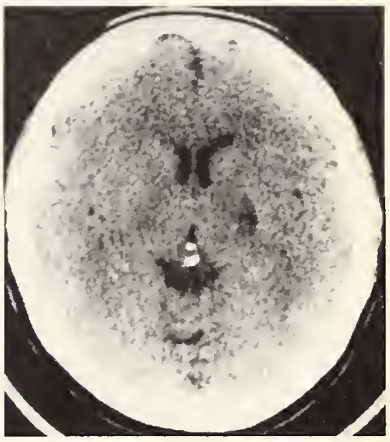


Figure 2
CCT showing low-density lesion in medial aspect of the left globus pallidus and posterior limb of the internal capsule.

was 35.9°C, blood pressure 120/68mm/Hg, pulse was 94 and regular, and respirations 20. She appeared anxious and was moderately obese. Her general physical and cardiovascular examination results were unremarkable. Neurological examination showed normal mental status with no evidence of aphasia. On cranial nerve testing, she had a right supranuclear seventh nerve paresis. She had grade 1-2 strength in the right upper extremity (minimal movement with gravity eliminated) and grade three in the lower extremity (active movement against gravity). Sensory and cerebellar examination results were entirely normal. Muscle stretch reflexes were normal on the left side and increased diffusely on the right side with a right Babinski response.

Investigations at that time yielded a normal hemoglobin, coagulation profile and a Westergren sedimentation rate of 9mm/hr. Routine blood tests and urinalysis yielded normal results. RPR was non-reactive. T_3, T_4 and TSH were all normal. Test for antinuclear antibody, rheumatoid factor and complement all yielded negative results. A serum drug screen was positive only for salicylates. EKG, EEG, radionuclide brain scan and chest roentgenogram were normal. Doppler carotid studies were normal. M-mode and 2-D sector echocardiograms were normal. CCT scan showed a small hematoma in the left basal ganglia involving the medial aspect of the globus pallidus and posterior limb of the internal capsule (Fig. 1). Somatosensory evoked responses were unremarkable.

Throughout hospitalization, the patient remained normotensive. Phenelzine was stopped on admission and her headache and strength improved. Six days after admission, her right hemiparesis was minimal and she was headache-free. She was discharged and warned to remain off phenelzine. Consideration was given to starting a mild tricyclic antidepressant in the future if she remained depressed but neurologically stable.

When seen in the outpatient neurology clinic two weeks later she had almost completely recovered with a very minimal right facial weakness. Her blood pressure was 130/70mm/Hg. She admitted in retrospect that she had not adhered to her prescribed MAOI diet while on phenelzine and had eaten beef liver, bananas, and bouillon cubes during the weeks prior to her hemiplegia.

A month later, the patient returned to the emergency room complaining of a two-day onset of frontal head pressure discomfort. She had been told by local paramedics that her blood pressure was 180/105 and was advised to seek medical attention. She reported that recent outpatient blood pressure monitoring showed a range of blood pressures from 130/70 to 160/110mm/Hg. She had resumed phenelzine three days before for feelings of anxiety, and restarted it at 60mg/day on her own against the advice of her neurologist and psychiatrist.

At this time, the patient again admitted to MAOI dietary indiscretions. That day, she had started a high protein ketogenic diet ("Cambridge diet") consuming only 220 calories. On arrival to the ER, her blood pressure was 160/88mm/Hg. She was anxious but showed no change in neurological examination. Her neck was supple. A repeat CCT scan showed resolution of the hematoma with a subsequent small hypodense area (Fig. 2). She was advised to stop phenelzine as well as her liquid protein diet and arrangements were made for further psychiatric as well as neurological follow-up. The next day, blood pressure was 140/90 and there was no change in her neurological status.

Comment

Throughout history, neurologists had described hemiplegic vascular syndromes showing only motor manifestations. In 1961, C. M. Fisher defined a syndrome of pure motor hemiplegia (PMH), which seems to accurately describe this case presentation: "a paralysis complete or incomplete of the face, arm, and leg on one side unaccompanied by sensory signs, visual field defect, dysphasia or apractagnosia. In the case of brain stem lesions the hemiplegia will be free of vertigo, deafness, tinnitus, diplopia, cerebellar ataxia, and gross nystagmus."[1]

Fisher specified that these signs were to be applied only to the acute phase of a vascular insult. In a 1965 paper, he reported that the postmortem brain study of nine patients with this syndrome showed lesions in the internal capsule or basis pontis. He reviewed an additional 41 patients with PMH clinically and reported that the upper extremity was usually more affected than the lower. These patients were dysarthric 66%

of the time. He observed that in supratentorial lesions the lateral gaze was sometimes easier away from the hemiplegic side.

Fisher reported a good prognosis for recovery. All nine of Fisher's autopsied cases showed infarction as the etiology, which he believed was secondary to thrombosis. The infarcts were small "lacunes" involving penetrating branches of the middle cerebral, anterior choroidal, or basilar artery. Since he found that 48 of 50 patients were hypertensive, he felt that arterial hypertension was linked to the etiology. Fisher commented that although a small hypertensive hemorrhage in the internal capsule might theoretically produce PMH, at the time of this report he had never seen one and didn't expect to without additional signs (sensory, field loss, aphasia, disconnection syndrome).

Since 1965, other researchers have expanded on Fisher's concepts of PMH. Richter, *et al,*[2] reviewed 850 cases of stroke in a population of high hypertension prevalence and found only 3% incidence (25 patients) of PMH. They found that the prognosis for recovery as well as future cerebral ischemia varied little from other patients with infarction and that the PMH patients did not seem to have a higher incidence of hypertension. Since one-third of their patients showed positive brain scans, they suspected that these lesions were larger than reported by Fisher.

Chokroverty and Rubino[3] reported lesions in other areas, and etiologies other than infarction, in PMH (*e.g.* frontoparietal metastasis, medullary pyramidal infarction, and internal carotid artery occlusion). They also noted that although the clinical signs in PMH patients showed no sensory abnormalities, some of these patients showed attenuated somatosensory evoked responses.

Other authors have described other causes for PMH, including ischemia and edema of the motor cortex post-craniotomy for postoperative bleeding, nocardial motor cortex abscess and large superficial cortical infarctions.[4-6] Rascol, *et al*[6] studied 30 patients with PMH. They found ischemic lesions in 27 patients (primarily capsular, infrequently pontine), five of whom had two lesions. They categorized ischemic capsular lesions into three types, involving different arterial supplies. They reported that two patients showed small (2cm diameter) cerebral hemorrhages in the posterior internal capsule. Most of their PMH patients recovered well and regained the ability to walk; however, the patients with the largest lesions (type 1, capsulo-putaminal caudate) had the poorest recovery. Chronic hypertension was found in only 16 of 30 patients. Of 11 patients younger than age 60, only four were hypertensive, which led Rascol, *et al,* to suspect embolic or other etiologies causing arteriolar lesions. Weisberg[7] also reported hemorrhages in the capsular region as the etiology for PMH in three of thirty-three patients with a rapidly evolving deficit.

The patient described here had no evidence of embolic, carotid or hypertensive disease during her initial evaluation. Her small internal capsule basal ganglionic hemorrhage was in a location common for hypertensive intracerebral hemorrhage.[8] Rascol, *et al*[6] and Weisberg[7] have previously reported capsular hemorrhages with PMH. When the patient discussed here admitted to dietary indiscretions while taking phenelzine, we became suspicious of intermittent hypertensive crises.

The association of hypertensive crises as well as cerebral hemorrhages in patients on MAO inhibitors who consume foods high in tyramine is well established.[8,9] Caplan[8] cites a case of combined phenelzine and amphetamine ingestion and intracerebral hemorrhage. When our patient later resumed phenelzine against medical advice, hypertensive pressure recordings (documented by medical personnel) lent support to the notion that intermittent hypertensive episodes were a likely causal factor of her cerebral hemorrhage. Our patient not only did not adhere to a prescribed MAOI diet but also later pursued a low calorie high protein ketogenic diet. Since the reliability of the patient was poor, it is uncertain how long she had been following this diet. Diets of this type have been clearly shown to be a cause of sudden death in previously healthy obese young women.[10] At this time there are no reports associating cerebral hemorrhage with low calorie ketogenic diets. However, these diets have been associated with ventricular arrthmias and electrolyte imbalances. In view of the case presented here it may be worthwhile to investigate whether low calorie ketogenic diets contribute to blood pressure lability or cerebral hemorrhage.

Summary

We describe a case of pure motor hemiplegia in a 37-year-old woman who initially appeared to have no risk factors for stroke but who later demonstrated hypertensive episodes while not adhering to a MAOI diet and taking phenelzine. This adds another case to the literature of PMH caused by a hematoma in the posterior limb of the left internal capsule and globus pallidus.

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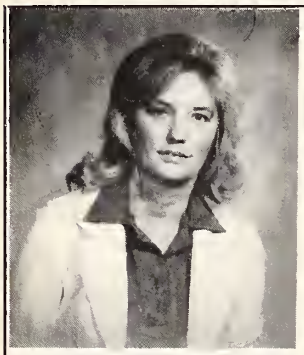
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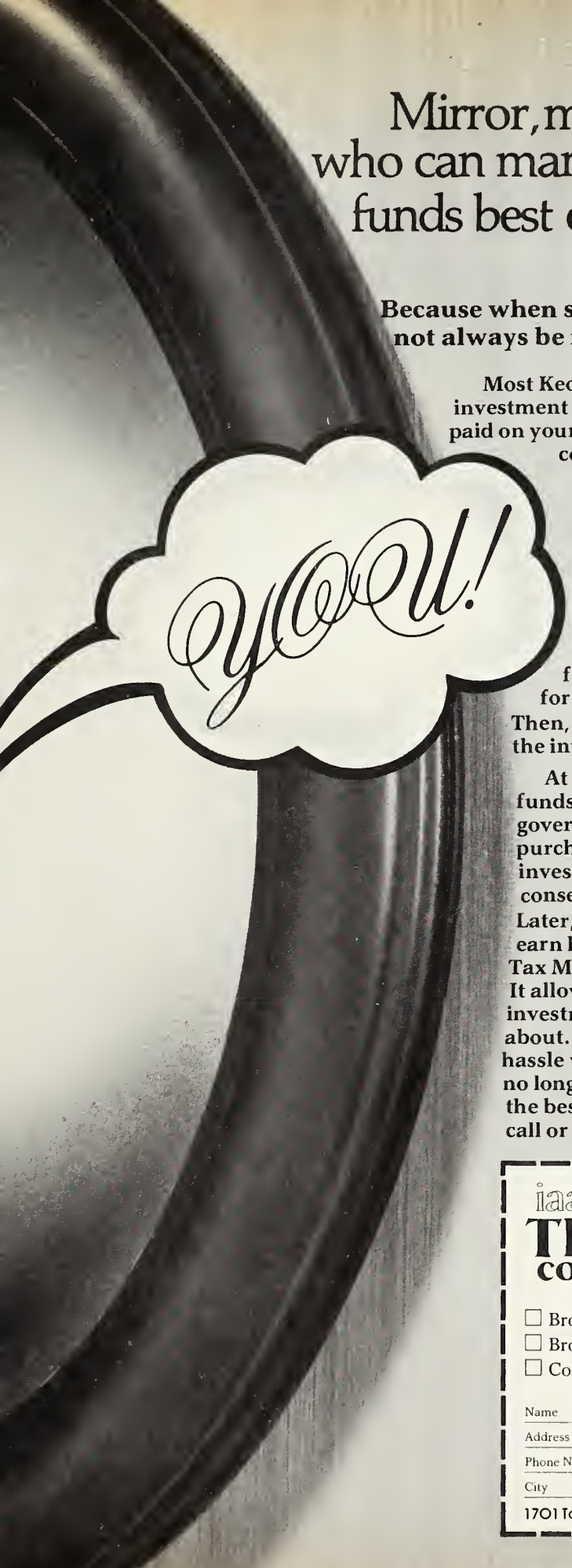


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Later, switch investments, whenever you can earn higher rates elsewhere. The flexibility of Tax MiniMiser® lets you do what's right for you. It allows you to have the best and least expensive investments offered by other plans you've read about. Plus, the ability to change them without hassle when you think their investment returns no longer meet your objectives. So, if you want the best management for your retirement funds, call or return the coupon for our free brochure.

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Doctor's News

PHYSICIANS IN THE NEWS—**William P. Gibbons, M.D.,** Downers Grove, has been installed as the 1983 Du Page County Medical Society president.

Gerald W. Grawey, M.D., corporate medical director of Caterpillar Tractor Co., Peoria, was elected president of the American Academy of Occupational Medicine at their recent annual meeting. Dr. Grawey is also an alternate delegate to the American Medical Association's House of Delegates for his specialty society.

Frank Jirka, M.D., Barrington, and **Henry B. Betts, M.D.,** Chicago, both received an annual Shepherd award presented by Good Shepherd Hospital. The award is given in recognition of each recipient's contributions to health care and the community.

The recently elected 1983 officers of the Tazewell County Medical Society are: **Wayne M. Keiserman, M.D.,** Pekin, president; **John E. Lovell, M.D.,** Tremont, president-elect and **Terry O. Tosi, M.D.,** Hopedale, secretary-treasurer.

Robert H. Libman, M.D., J.D., Chicago, president of the Irving Park Suburban Branch of the Chicago Medical Society, received a law degree from the DePaul University College of Law in February. Dr. Libman plans to pursue his interests in the areas of medical malpractice and physician-hospital relations.

Virendra S. Saxena, M.D., River Forest has been elected 1983 medical staff president at Christ Hospital, Oak Lawn.

Robert Swastek, M.D., Chicago, has been named vice president of medical affairs at Saint Mary's of Nazareth Hospital Center, Chicago.

The 1983 Peoria Medical Society officers are: **Lorin D. Whittaker, Jr., M.D.,** president; **Chester C. Danehower, M.D.,** president-elect; **Thomas G. Cassidy, M.D.,** secretary; **Irving J. Weigensberg, M.D.,** treasurer; all of Peoria.

Robert W. Wissler, M.D., Chicago, received the Distinguished Service Award by the International Atherosclerosis Society this past summer for his services to the field of atherosclerosis research.

Arthur T. Haebich, M.D., Riverwoods, president of the medical staff at Illinois Masonic Medical Center, was recently named an honorary member of the IMMC Board of Trustees. A clinical associate professor of surgery at the University of Illinois, Dr. Haebich is a board certified general and thoracic surgeon. After co-founding the Illinois Thoracic Surgical Society, Dr. Haebich served as its president, vice-president and secretary.

FLYING PHYSICIANS ASSOCIATION ANNUAL MEETING—Physicians interested in attending the FPA annual meeting in Grand Teton National Park, June 19-24, may contact Seymour Polk, M.D., 777 Pollard Road, 5, Los Gatos, California 95030.

MALPRACTICE SUITS CLIMB—The number of malpractice suits against physicians continues to climb. Some 1100 physicians were named in professional liability suits in Cook County during 1982, according to the *Cook County Jury Verdict Reporter.* That number represents an increase of 25% over the previous year.

Overall, the number of health related suits increased 17% from 1327 in 1981 to 1548 in 1982. Since 1974, the annual number of health-related malpractice suits jumped an astronomical 223%.

EXCHANGE REDEEMS MORE GFCs—The Illinois Department of Insurance has authorized the Illinois State Medical Inter-Insurance Exchange to redeem an additional $128,000 in Guaranty Fund Certificates (GFCs). The latest redemptions reflect policyholder deaths or retirements and brings to more than $10.7 million the amount returned to purchasers of GFCs by the Exchange. Purchase of GFCs was required of policyholders during the Exchange's initial policy years to provide operating capital for the physician-owned company.

MATERNAL AND CHILD HEALTH TRAINING PROGRAM—Obstetricians, pediatricians and other physicians interested in maternal and child health may now apply to the Graduate School of Public Health, San Diego State University, for a nine-month program beginning in August. Upon completion of the program, the student will earn a master of public health degree.

In addition, pediatricians may apply for a 21-month program in caring for handicapped children.

Send inquiries to: Helen M. Wallace, M.D., Professor and Head, Division of Maternal and Child Health, Graduate School of Public Health, San Diego State University, San Diego, CA 92182.

PATIENT MEDICAL INSTRUCTION SHEETS—The AMA has launched a Patient Medical Instruction (PMI) program to help physicians educate their patients about prescribed drugs. The program is designed to improve the effectiveness of therapy and alleviate misuse of prescribed medication as well as answer questions patients might have concerning their prescriptions.

PMI leaflets describe the type of drug prescribed, uses of the medicine, dosage, precautions in usage and side effects. There are blank spaces for the physician to fill in the patient's name, drug prescribed, directions for use and special instructions. The PMI sheets are intended to supplement, not supplant, the instructions physicians give each patient.

PMI pads, containing 100 sheets, list the generic and brand names of drugs that fall within the class covered by that particular PMI. Forty PMIs are now available: Furosemide, Thiazide Diuretics, Penicillins-Oral, Beta Blockers, Digitalis medicines, Coumarin-Type Anticoagulants, Oral Antidiabetes Medicines, Tetracyclines, Cephalosporins-Oral, Erythromycin, Nonsteroidal Anti-inflammatory Drugs, Benzodiazepines, Nitroglycerin Sublingual Tablets, Methyldopa, Insulin Corticosteroids-Oral, Cimetidine, Belladona Alkaloids and Barbiturates, Phenytoin, Sulfonamides, Lithium, Haloperidol, Hydralazine, Guanethidine, Valproic Acid, Ethosuximide, Allopurinol, Oral Xanthine Derivatives, Thyroid Replacement, Metronidazole, Oral Clindamycin/Lincomycin, Oral Chloramphenicol, Levodopa/Carbidopa and Levodopa, Ergot Derivatives, Indomethacin, Phenylbutazone/Oxyphenbutazone, Quinidine/Procainamide, Iron Supplements, Verapamil, and Nifedipine.

More than $2.9 million have been invested in the PMI program, developed as a voluntary private sector alternative to the Food and Drug Administration's recently-rescinded Patient Package Insert (PPI) program. AMA urges physicians to utilize the program to help improve the effectiveness of drug therapy, reduce the risk of improper drug use, decrease the incidence of preventable and serious adverse drug reactions, strengthen physician/patient relationships and enhance patient compliance.

To request samples or order blanks, write to: AMA Order Department, PMI Program, 535 North Dearborn Street, Chicago, Illinois 60610.

MEDICAL PUBLICATIONS AND COMPUTER TAPES AVAILABLE—The Commission on Professional and Hospital Activities (CPHA) has announced the availability of recently published medical information volumes and computer tapes of hospital statistics. PROBE is a new series of publications focusing on case mix and other aspects of hospital utilization practices. For more information, contact the CPHA, 1968 Green Road, P.O. Box 1809, Ann Arbor, Michigan 48106.

COLLEGE SEEKS FELLOWS—The Interamerican College of Physicians and Surgeons is seeking active fellows. The non-profit organization was initiated by Hispanic American physicians practicing medicine in the United States, Mexico, the Caribbean, and Central and South America. Interested candidates should contact Rene F. Rodriguez, M.D., president, Interamerican College of Physicians and Surgeons, 299 Madison Ave., New York, N.Y. 10017.

PISART VISION AWARD—The New York Association for the Blind is accepting nominations for the third annual Lighthouse Pisart Vision Award, to be presented on September 13, 1983. The award honors those who have contributed most significantly to the prevention, cure, treatment or care of blindness.

Nominations for the Pisart Vision Award must be postmarked by May 2, 1983. For more information contact: Florence Cayer, Coordinator, Lighthouse Pisart Vision Award, The New York Association for the Blind, 111 East 59th St., New York, N.Y. 10022; (212) 355-2200, ext. 172.

INSTITUTE OF CHRONOBIOLOGY—The New York Hospital-Cornell Medical Center, Westchester Division, has announced the establishment of the Institute of Chronobiology. The institute has three subdivisions: the laboratory of human chronophysiology, the sleep-wake disorders center and the erectile disorders program.

Brochures describing the institute's services can be obtained by calling (914) 997-5825 or the sleep-wake disorders center (914) 997-5751.

COUNTY JAIL WINS AWARD—Robert C. Hamilton, M.D., Chicago, recently presented the American Medical Association's Certificate of Accreditation to the Cermak Health Services of the Cook County Department of Corrections. The award certifies that the facility meets the AMA's *Standard for Health Services in Jail (1981)* criteria. Representing the AMA, ISMS and CMS, Dr. Hamilton presented the award to Cook County Board President George Dunne and Sheriff Richard J. Elrod.

INSURANCE CLAIMS DATA COMMITTEE FORMED—In a continuing attempt to help physicians cope with the professional liability situation, the Illinois State Medical Insurance Services Board of Directors has established a special committee to analyze insurance claims data. The committee will organize a system that can provide available claims data information for loss prevention activities, medical education and risk management/underwriting purposes. Appointed to the "Committee to Study the Organization of Claims Data" were Alfred Clementi, M.D., of Arlington Heights, Chairman, Donald Aaronson, M.D., of Des Plaines, Fred Z. White, M.D., of Chillicothe and Irwin A. Smith, M.D., of Northbrook.

CAR SEAT PAMPHLETS AVAILABLE FROM ISMS—Physicians now can order from ISMS patient information brochures regarding infant and child car seats to assist patients in complying with a new Illinois law requiring car seats for children under 2 years old. Packets of 100 phamphlets each are available at a cost of $16 from the Division of Medical Services, ISMS, 55 E. Monroe, Suite 3510, Chicago, IL 60603. Checks should be payable to "ISMS Car Seats."

MEDICAL COORDINATOR APPOINTED—Springfield physician John V. Standard, M.D., has been named medical coordinator for the Illinois Department of Registration and Education Medical Disciplinary Board. As medical coordinator, he will serve as chief enforcement officer of the Medical Practice Act, the state law defining professional conduct for physicians and chiropractors. Dr. Standard also is expected to take a more active role in investigative matters and help facilitate the new mandatory reporting program established by law last year.

MAJOR MEDICAL INSURANCE PLAN IMPROVED—ISMS members may take advantage of significant improvements in the major medical insurance plan. Some important highlights of the plan include (1) $500,000 lifetime maximum benefit; (2) choice of three calendar year deductibles—$500, $1,000 or $2,000 and (3) three-family member deductible limit during a calendar year.

For more details about this comprehensive medical insurance, members may call the ISMS insurance department.

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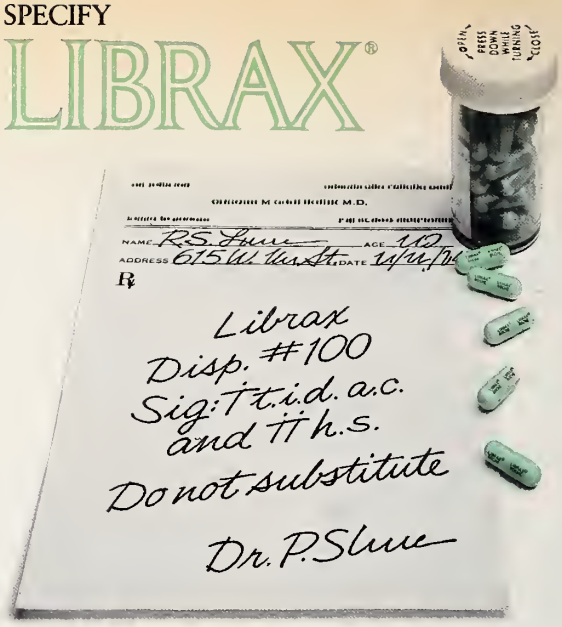
(Continued from page 248)

Answers: 1. E 2. B, C, D

No P waves are seen and the QRS morphology has changed. Atrial fibrillation developed but conducted to the ventricles only in beats 2, 3, 4, 10, 11, and 12. These six beats have a QRS contour of complete left bundle branch block and irregular R-R cycles. In contrast, beats 1 and 4 through 8 have a narrow QRS with a QR pattern in lead V_1 and regular R-R cycles. These beats cannot be conducted from the atria because they are regular. In addition, the QRS morphology is different. This is an accelerated junctional rhythm with aberrant intraventricular conduction. The development of a regular rhythm in the presence of atrial fibrillation suggests digitalis intoxication and AV dissociation. A serum digoxin level was ordered and the drug was held. The serum digoxin level was only 0.4ng, actually the low therapeutic range. Holding digoxin had no effect on this arrhythmia. In the absence of any AV blocking drug, atrial fibrillation with a slow ventricular response with or without a junctional escape rhythm suggests an advanced AV block. A pacemaker would be recommended. Another cardiac catheterization would not be needed at this point. This patient was a high risk case because of his left ventricular dysfunction. This patient had poor left ventricular function preoperatively manifested by an episode of clinical congestive heart failure and a left ventricular end diastolic pressure of 36mmHg at catheter study. The postoperative development of atrial fibrillation, the loss of atrial systole, and a relatively slow ventricular rate all contributed to postoperative low cardiac output syndrome. Dobutamine was used successfully to raise cardiac output with a temporary demand pacemaker. On the ninth day, a permanent ventricular demand pacemaker was inserted. In addition, digoxin and a diuretic were required. ◀

SPECIFY

LIBRAX®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

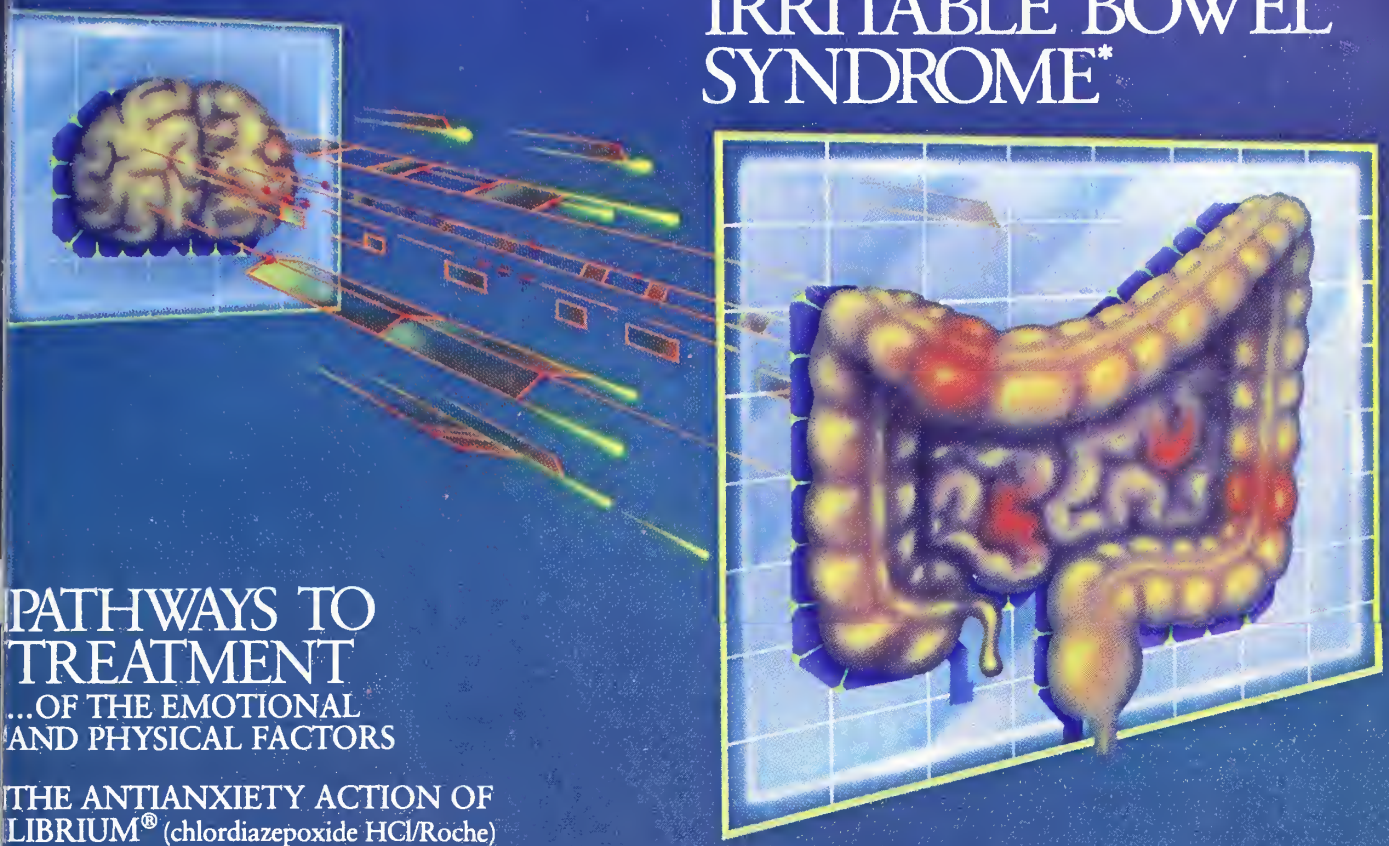
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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PATHWAYS TO IRRITABLE BOWEL SYNDROME*



Illustrated here is the connection between emotional anxiety and the altered state of intestinal motility of irritable bowel syndrome.[1-3] While no abnormalities may be seen after physical examination or blood tests on these patients,[2] the slow rhythms of their intestines have been found to be more prominent than normal when they are symptomatic *and* when they are symptom-free.[3]

PATHWAYS TO TREATMENT
...OF THE EMOTIONAL AND PHYSICAL FACTORS

THE ANTIANXIETY ACTION OF LIBRIUM® (chlordiazepoxide HCl/Roche)

The presence of Librium in the Librax combination serves as a calming agent for the patient with irritable bowel syndrome. Librium has an unequaled record of efficacy and safety and seldom impairs mental acuity. Patients should be cautioned, however, about taking any CNS-acting agent while performing activities that are hazardous or require complete mental alertness.

THE ANTISPASMODIC/ ANTISECRETORY ACTIONS OF QUARZAN® (clidinium bromide/Roche)

The Quarzan in Librax provides anticholinergic action that can aid in the control of hypersecretion and irregular intestinal motility to relieve the distressing abdominal symptoms of irritable bowel syndrome.

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of irritable bowel syndrome.
Please see brief summary of prescribing information on preceding page.

References: 1. Sandler RS, Drossman DA: *Intern Med 2*(1):39-47, Jan 1981. 2. Mendeloff AI: *Practical Gastroenterol 3*(3):12-18, May-Jun 1979. 3. Connell AM: *The Female Patient 5*(9):20-22, Sep 1980.

SPECIFY ADJUNCTIVE

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

ANTIANXIETY
ANTISECRETORY
ANTISPASMODIC

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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

April 25	Lutheran General Hospital	Park Ridge
April 26	Rich Central High School & Chgo. Lung Assn.	Olympia Fields
April 28	Northwestern Memorial Hosp. & Chicago Lung Assoc.	Chicago
May 2	Carle Clinic	Urbana
May 2	Hinsdale Sanitarium & Hosp. & ACS	Hinsdale
May 2	Mercy Health Center	Justice
May 2	St. Theresa Area Trauma Satellite & ACS	Lake Villa
May 3	Chgo. Lung Assoc.	Olympia Fields
May 3	Ill. Interagency Council On Smoking & Disease/Chgo. Health Dept.	Chicago
May 3	Northwestern Memorial Hosp. & Chgo. Lung Assoc.	Chicago
May 16	Lutheran General Hospital	Park Ridge
May 17	St. Francis Hospital & ACS	Blue Island
May 19	ACS Training	Chicago
May 24	Olympia Fields Osteopathic & ACS	Olympia Fields
June 7	Ill. Interagency Council On Smoking & Disease/Chgo. Health Dept.	Chicago
June 20	Lutheran General Hospital	Park Ridge
July 11	Carle Clinic	Urbana
July 11	Mercy Center in Aurora	Aurora
July 18	Anchor	Chicago
July 18	Lutheran General Hospital	Park Ridge
Aug. 3	Holy Family Ambulatory Center & ACS	Wheeling
Aug. 15	Lutheran General Hospital	Park Ridge

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® CAPSULES For Oral Use
(nifedipine)

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LOH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

[*] Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

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THE NEUROLOGICAL CENTER provides the medical community with the most advanced forms of diagnostic procedures, care and training in the field of neurology, neuro-imaging and cardio-vascular imaging.

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Viewbox

(Continued from page 245)

Diagnosis: Primary Tuberculosis



Figure 3
Lateral view of hilus of patient. The left upper lobe bronchus (arrows) is encircled by enlarged lymph nodes causing a "doughnut" appearance.

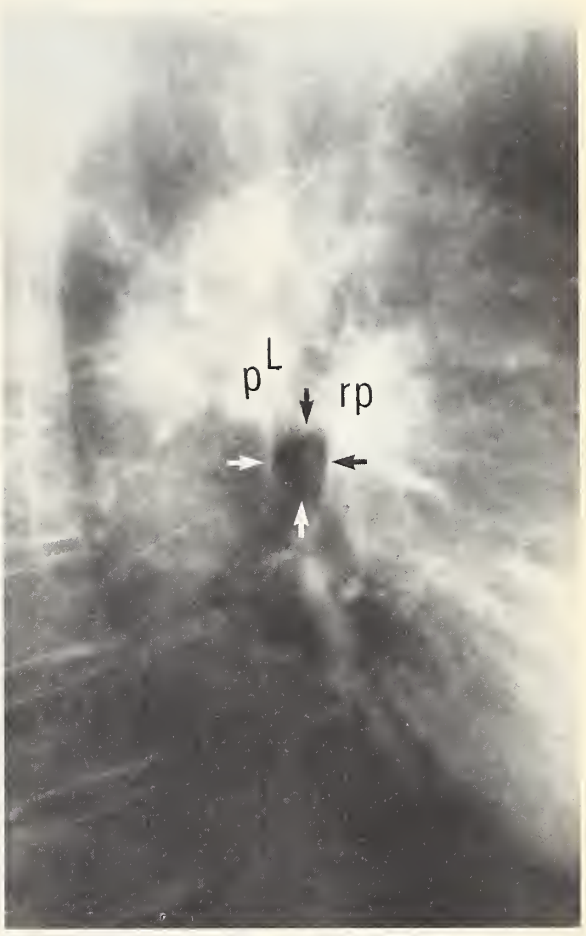


Figure 4
Lateral view of normal hilus. Left upper lobe bronchus (arrows). The left pulmonary artery (Lp) arches behind the bronchus (arrows). The right pulmonary artery (Rp) is an oval density in front of the bronchus.

All of the choices can present with intrathoracic lymphadenopathy. Mycoplasma pneumonia would have parenchymal lung changes after three weeks. Sarcoidosis rarely causes unilateral hilar adenopathy. Hodgkin's disease and seminoma would both be reasonable choices. Primary tuberculosis is in keeping with the fever and night sweats and has been reported in several patients after I-J bypass.

In Figures 1 and 2, the right hilus is enlarged by lymphadenopathy. The lateral view of the abnormal right hilus is pictured again (Figure 3) with a lateral view of a normal right hilus (Figure 4) for comparison. In primary tuberculosis, unilateral lymphadenopathy occurs frequently. The diagnosis of tuberculosis was made in this patient by mediastinal lymph node biopsy.

In the 1940's the tuberculin reactivity rate of 35-year-old adults in the United States was 50-85%. Thirty years later, in 1976, it was reduced to 5-25% except in endemic areas. Previously, primary tuberculosis was a childhood disease, while presently, it is an important disease afflicting adults. When first discovered on chest radiographs in adults, mediastinal and hilar lymphadenopathy

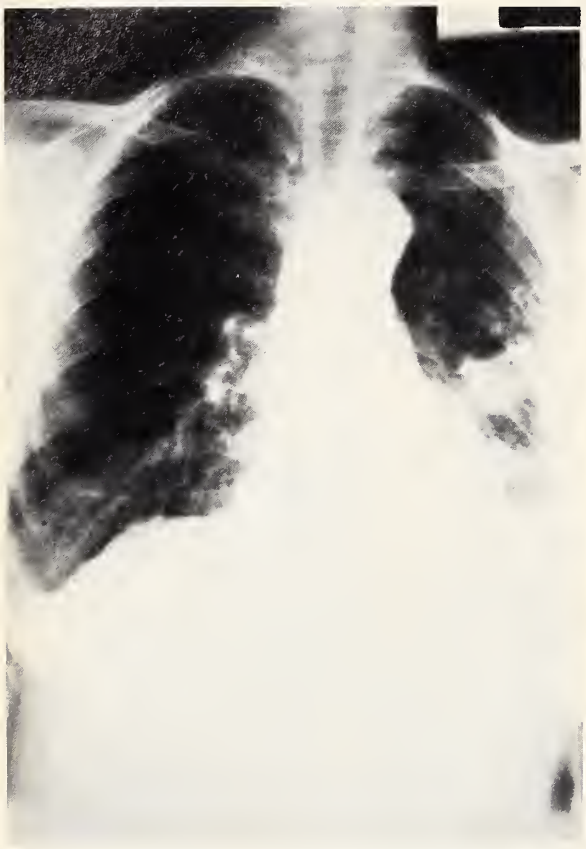


Figure 5
PA view of a 73-year-old woman's chest who complains of fevers and night sweats for the past 6 months. Her sputum shows acid fast bacilli. The chest film demonstrates a left lower lobe infiltrate and left pleural effusion.

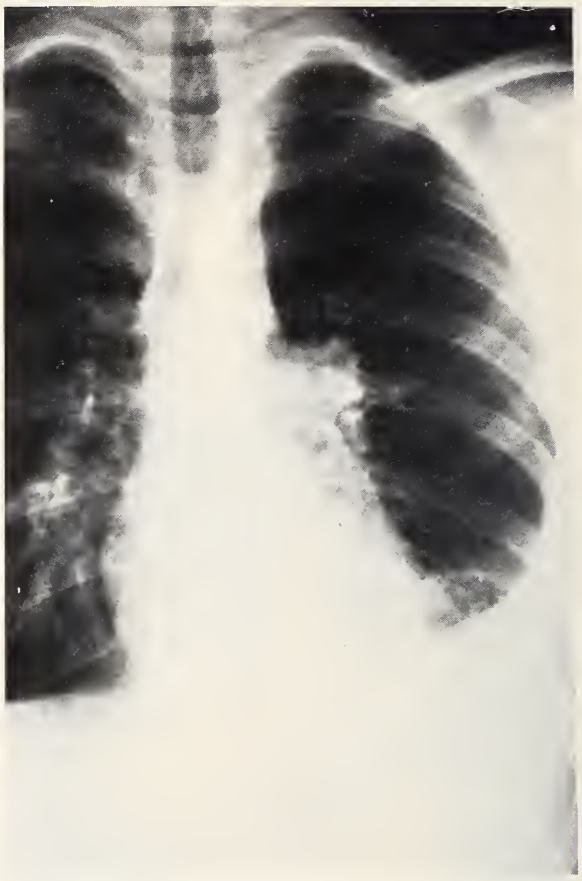


Figure 6
PA radiograph of a 13-year-old boy who has pleuritic chest pain and increasing pleural effusion despite antibiotic therapy. The pleural biopsy was positive for caseating granuloma. The radiograph shows left hilar adenopathy and a left pleural effusion.

due to tuberculosis is often mistaken for other disease, especially malignancy.

Pathophysiology

When an uninfected person inhales infectious particles containing mycobacterium tuberculosis, these particles can lodge in lung airways. Most particles die or are removed from the body by ciliary action or macrophage ingestion. Initially, a local inflammatory reaction occurs which is an infiltrate that histologically resembles any other pneumonic process. It is often not visible on radiographs. This area of pneumonitis may resolve completely, partially resolve and form fibrous scars, necrose or calcify.

A few weeks after the initial local infection occurs, lymphatic spread to the hilar and mediastinal lymph nodes can occur. The supraclavicular and cervical nodes may also be involved. At this stage, there is hematogenous spread to distant parts of the body as well as the lungs. Days to weeks later, delayed hypersensitivity and cellular immunity develop. When this immunologic response occurs, multiplication of the mycobacterium is inhibited and the patient's skin test turns tuberculin positive.

The absolute criterion for diagnosis of tuberculosis as primary is conversion of the tuberculin skin test. Many patients have not had previous skin tests, so it is impossible to satisfy this criterion. Other indications of primary infection have been reported as common in primary tuberculosis but rare in post primary tuberculosis. These include: enlargement of the hilar lymph nodes with a parenchymal lung lesion in the mid or lower lung, exudative tuberculous pleural effusion with no radiographic lung lesions, and lower lobe or anterior segment of the upper lobe

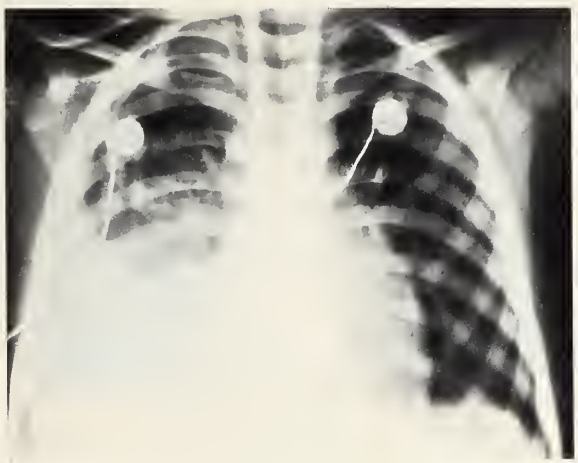


Figure 7
PA chest radiograph of a three-year-old boy shows a right lower lobe infiltrate and right pleural effusion. The pneumonia was unresponsive to antibiotic therapy. Smears of the pleural effusion showed acid fast bacilli.

parenchymal lesions that clear with antituberculous drug therapy.[1,2]

Clinical

The clinical presentation of a patient with primary tuberculosis producing radiograph findings can be quite varied. It can range from no clinical illness with an abnormal chest radiograph found coincidentally, to severe illness. The most common findings are fever and weight loss. Cough, chest pain, fatigue and lymphadenopathy are reported less frequently.[2,3,8]

Radiology

The incidence of tuberculin sensitized adults has decreased significantly over the past three decades, so a greater proportion of the adult population is susceptible to primary infection. No longer is primary tuberculosis a disease of children and adolescents: now it is seen with increasing frequency in adults. Primary tuberculosis can involve the lung parenchyma, pleura, and lymph nodes. The spectrum of chest radiographic findings in primary tuberculosis includes a normal chest, parenchymal consolidation, pleural effusion, hilar and mediastinal adenopathy, and miliary lesions.[1,2,4] Common manifestations of the disease include unilateral pleural effusion with or without intrathoracic adenopathy, or unilateral infiltrate with ipsilateral intrathoracic adenopathy or pleural effusion (Figures 5, 6, 7).[1,2,4] In children, hilar and paratracheal adenopathy as the only manifestation of primary tuberculosis is a very well known finding. In contrast, adults who present solely with intrathoracic lymphadenopathy on radiographs are likely to be diagnosed initially as having a different disease process (Table 1) and as a consequence of this, incorrect diagnosis may cause a delay in appropriate therapy and result in unneeded diagnostic studies.

Table 1
Some Causes of Mediastinal Lymphadenopathy

Mediastinal, Hilar Lymphadenopathy	
	Lung Neoplasm
	Metastasis
	Lymphoma, Leukemia
	Sarcoidosis
	Pneumoconiosis
	Primary Tuberculosis
	Agammaglobulinemia
	Amyloidosis
	Collagen Diseases
	Cystic Fibrosis
	Drugs
	Erythema Nodosum
	Extrinsic Alveolitis
	Heavy Chain Disease
	Histiocytosis X
Lymph Node Disorders	
	Lymphadenitis
	Castleman Disease
	Immunoblastic Lymphadenopathy
	Sinus Histiocytosis
Angitis and Granulomas	
	Wegener's Granulomatosis
	Lymphomatoid Granulomatosis
	Allergic Granulomatosis
Bacterial Infection	
	Anthrax
	Brucellosis
	Mycoplasma
	Ornithosis
	Pertussis
	Plague
	Tularemia
Viral Pneumonia	
	Rubeola
	Echo
	Epstein-Barr
	CMV
Parasitic	
	Toxoplasmosis
	Tropical Eosinophilia

Intrathoracic lymphadenopathy in primary tuberculosis follows no set pattern. Unilateral as well as bilateral lymphadenopathy occur. Both the paratracheal and hilar regions can be involved in combination or alone (Figs. 8-10).[3,4,6,7]

Treatment

The treatment of choice in primary tuberculous lymphadenopathy is drug therapy. The regimen

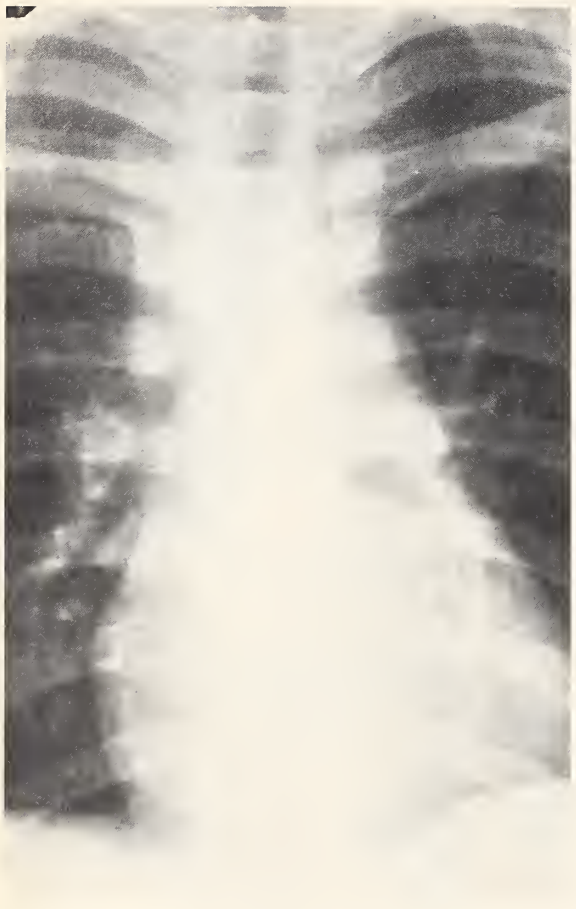


Figure 8
PA chest radiograph of a 20-year-old woman who complains of a 20 pound weight loss and swelling on the right side of the neck. Note the hilar and paratracheal lymphadenopathy.



Figure 9
This is the PA radiograph of a 29-year-old medical intern who is a recent PPD converter. There is unilateral hilar and paratracheal lymphadenopathy.

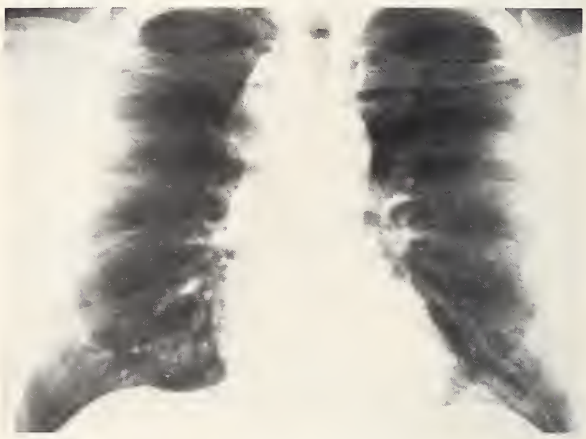


Figure 10
This is the same patient as in Figure 9, but one year later. Notice that the lymphadenopathy had increased.

is isoniazid and rifampin for a duration of 18-24 months. For patients known to have been exposed to drug-resistant organisms, three drugs are used. The third drug is ethambutol or streptomycin. In response to treatment, reduction in the size of the lymph nodes may take months to years. The lymphadenopathy may worsen before shrinking in size under therapy. ◀

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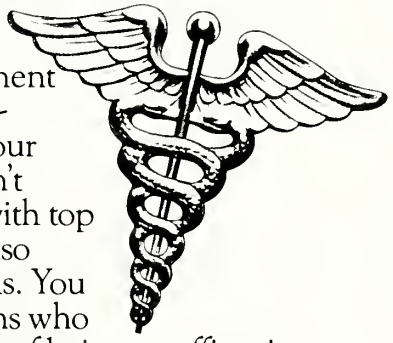
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MAY

Anesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, May 1-6, Chicago. **Speaker:** Alan Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $525. **Reg. limit:** 450. **Credit:** Category 1, 54 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Back Pain

Back Pain Conference
For: MD's. Conference, May 13-14, Madison, WI. **Sponsor:** U of WI—Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** TBD. **Reg. limit:** none. **Credit:** TBD. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Cardiac Rehabilitation

Cardiac Rehabilitation Symposium
For: MD's. Symposium, May 4-6, Milwaukee, WI. **Sponsor:** U of WI—Extension, CME, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $250, MD; $155, other. **Reg. limit:** none. **Credit:** TBD. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Cardiology

Treatment of Acute Myocardial Infarction
For: MD's. Symposium, May 18, 6:00 p.m., Highland. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Dermatology

Dermabrasion, Chemical Peel, Silicone, Collagen
For: Dermatologists. Workshops/lectures, May 18-21, Chicago. **Sponsors:** The American Society for Dermatologic Surgery; Northwestern University, 303 E. Chicago Ave., Chicago 60611. **Fee:** none. **Reg. limit:** 100. **Credit:** Category 1. **Contact:** Henry Roenigk, Jr., MD. **Phone:** 312-649-8173.

Family Medicine

Specialty Review in Family Practice
For: FP's. Lecture, May 31-June 11, Chicago. **Speaker:** Harry Morchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $600. **Reg. limit:** 90. **Credit:** Category 1, 91 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Medical Ethics

Medical Ethics
For: MD's. Lecture, May 18, 12:30 p.m., Holiday Inn of Oak Brook. **Sponsor:** DuPage County Medical Society, 800 Roosevelt Rd., Bldg. 8, Suite 300, Glen Ellyn 60137. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Lillian Widmer. **Phone:** 312-858-9603.

Medicine

Gastroenterology
For: MD's. Symposium, May 26, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Medicine

Dermatologic Therapeutics in General Practice
For: MD's. Symposium, May 17, 7:00 p.m., Effinghom. **Fee:** $40. **Reg. limit:** none. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Neurosurgery

Stroke: Something Can Be Done
For: Neurosurgeons, Internists, FP's. Lecture, May 13, Westin Hotel, Chicago. **Speaker:** Louis Caplan, MD. **Sponsor:** Dept. of Neurosurgery, U of I College of Medicine, 912 S. Wood St., 2nd floor north, Chicago 60612. **Reg. deadline:** 4/28. **Fee:** $60. **Credit:** Category 1, 6 hours. **Contact:** Sue Korienek. **Phone:** 312-996-8025.

Ob-Gyne

Specialty Review in Ob-Gyne, Part 1
For: Obstetricians, Gynecologists. Lecture, May 16-21, Chicago. **Speaker:** M. LeRoy Sprong, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $425. **Reg. limit:** none. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Orthopedics

Specialty Review in Orthopedics
For: Orthopedic Surgeons. Lecture, May 22-28, Chicago. **Speakers:** Peter Altner, M.D.; James Callahan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** none. **Credit:** Category 1, 68 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathology

Non-Hodgkin's Lymphoma
For: MD's. Lecture, May 9, 7:00 p.m., Chicago. **Speaker:** R. J. Hartsock, MD. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Reg. deadline:** 4/29. **Fee:** dinner only. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312-626-4300.

Pediatrics

Pediatrics
For: MD's. Symposium, May 25, 1:00 p.m. Nashville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Stroke

What Can Be Done About Preventing Stroke?
For: Neurologists, Psychiatrists, Internists, FP's. Lecture, May 19, 8:30 a.m., Melrose Park. **Speaker:** Clark Millikan, MD. **Sponsor:** The Center for Rehabilitation at Westlake Community Hospital, 1225 Superior St., Melrose Park 60160. **Fee:** none. **Reg. limit:** 150. **Credit:** Category 1, 2 hours. **Contact:** Alison Rudzinski. **Phone:** 312-681-3000 x 3686.

Surgery

Newer Concepts in Colon and Rectal Surgery
For: General Surgeons. Symposium, May 18-20, Chicago. **Sponsors:** U of I College of Medicine, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Reg. deadline:** 5/18. **Fee:** $250. **Reg. limit:** 300. **Credit:** Category 1, 19 hours. **Contact:** Lloyd Nyhus, MD. **Phone:** 312-996-6765.

Surgery

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists. Lecture, May 2-4, Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Advances in Surgery
For: General and Specializing Surgeons. Lecture, May 2-6, Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $375. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, M.D. **Phone:** 312/733-2800.

Surgery

The Management of Burn Patients Today
For: MD's. Symposium, May 26, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield, 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

JUNE

Cardiology

Cardiac Rehabilitation
For: GP's, FP's, Internists. Seminar, June 10-11, Hyatt Regency, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr., E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** $260. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

Geriatrics

Geriatric Problems
For: MD's. Symposium, June 2, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Heodoche

Annual Meeting
For: MD's, DO's, DDS's. Lectures, June 24-26, Four Seasons Hotel, Toronto, Canada. **Sponsor:** American Associatian for the Study of Headache, 5252 N. Western Ave., Chicago 60625. **Reg. deadline:** 6/1. **Fee:** $100, non-members. **Reg. limit:** none. **Credit:** Categary 1, 18 haurs; AAFP Prescribed, 18 haurs; AOA, 2-D. **Cantact:** Seymaur Diomond, MD. **Phone:** 312/878-5558.

Internal Medicine

Internal Medicine Symposium
For: MD's. Symposium, June 17-18, Springfield. **Sponsor:** SIU School af Medicine, P.O. Bax 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Cantact:** Larraine Stephenson. **Phone:** 217/782-7711.

OB/GYN

Open Laparoscopy Warkshap
For: Ob/Gyn, Surgeons, FP's. Warkshap, June 4, 8:00 a.m., Chicaga. **Sponsar:** Grant Haspital, 550 W. Webster Ave., Chicago 60614. **Reg. deadline:** 5/15. **Fee:** $150; residents, $75. **Reg. limit:** 100. **Credit:** ACOG, 7 hours. **Contact:** Horrith Hossan, MD. **Phone:** 312-883-5638.

OB-GYN

Ob-Gyn Review Caurse
For: MD's. Caurse, June 6-11, Americano Congress Hatel, Chicaga. **Sponsars:** 7 medical schaals in Illinais. **Fee:** $450; $350, residents. **Reg. limit:** nane. **Credit:** Category 1, 34 haurs; ACOG cagnates, 34. **Cantact:** CME, University af Chicaga, 950 E. 59th St., Bax 139, Chicaga 60637. **Phone:** 312/962-1056.

Pathology

Liver & GI Clinica-Pathalagic Conference
For: MD's. Lecture, June 28, 4:30 p.m., Narth Chicaga. **Sponsar:** Dept. af Pathalagy, UHS/CMS, 3333 Green Bay Rd., Narth Chicaga 60064. **Fee:** nane. **Credit:** Categary 1, 2 haurs. **Cantact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Pathology

Laboratary Evaluatian af Cerebrospinal Fluid
For: Pathalagists. Lecture, June 13, 7:30 p.m., Drake Hatel, Chicaga. **Sponsar:** Chicaga Pathalagy Saciety, c/a Marshall Shart, M.D., Loretta Haspitol, 645 S. Central Ave., Chicaga 60644. **Casponsar:** Michael Reese Haspital. **Fee:** nane. **Reg. limit:** none. **Credit:** Categary 1, 2 haurs. **Phane:** 312/626-4300 x 383.

Pulmonary Diseose

Pulmanory Medicine Update
For: MD's. Canference, June 17-18, Madisan, WI. **Sponsar:** University af WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madisan, WI 53706. **Fee:** yes. **Reg. limit:** nane. **Credit:** Category TBD. **Cantact:** Sarah Aslakson. **Phane:** 608/263-2856.

Dermotology

Practical Office Dermatalagy
For: Internists, Pediatricians, FP's, GP's. Lecture, July 12-16, Chicaga. **Speaker:** Marshall Blankenship, MD. **Sponsar:** Cook County Graduate School af Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $350. **Reg. limit:** 85 haurs. **Credit:** Categary 1, 37 haurs. **Cantact:** Robert Baker, MD. **Phane:** 312-733-2800.

Gynecology

Office Gynecalagy
For: Internists, FP's, GP's. Lecture, July 12-14, Chicaga. **Speaker:** M. LeRay Sprang, MD. **Sponsar:** Cook Caunty Graduate School af Medicine, 707 S. Waad St., Chicago 60612. **Fee:** $250. **Reg. limit:** 85. **Credit:** Categary 1, 21 haurs. **Cantact:** Rabert Baker, MD. **Phane:** 312-733-2800.

Medicine

Enviranmental Medicine
For: Internists, FP's, GP's, Occupotionol Medicine. Lecture, July 19-23, Chicaga. **Speakers:** Stephen Greenberg, PhD; Emersan Day, MD. **Sponsar:** Cook Caunty Graduate School af Medicine, 707 S. Waad St., Chicaga 60612. **Fee:** $325. **Reg. limit:** 85. **Credit:** Categary 1, 30 haurs. **Cantact:** Robert Baker, MD. **Phane:** 312-733-2800.

Medicine

Specialty Review in Internal Medicine/Certifying
For: Internists. Lecture, July 25-Aug. 1, Chicaga. **Speaker:** Sheldan Waldstein, MD. **Spansar:** Caak Caunty Graduate Schaal af Medicine, 707 S. Waad St., Chicaga 60612. **Fee:** $450. **Reg. limit:** 600. **Credit:** Categary 1, 72 haurs. **Cantact:** Robert Baker, MD. **Phane:** 312-733-2800.

Pathology

Liver & GI Clinica-Pathalagic Conference
For: Pathalagists. Lecture, July 26, 4:30 p.m., Narth Chicaga. **Sponsar:** Dept. af Pathalagy, UHS/CMS, 3333 Green Bay Road, Narth Chicago 60064. **Fee:** nane. **Credit:** Categary 1, 2 haurs. **Cantact:** Ben Blivaiss, PhD. **Phane:** 312-578-3215.

Pediotrics

Specialty Review in Pediatrics
For: Pediotricions. Lecture, July 19-24, Chicaga. **Speaker:** Ira DuBraw, MD. **Sponsar:** Cook County Graduate Schaal af Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 300. **Credit:** Categary 1, 63 haurs. **Cantact:** Rabert Baker, MD. **Phane:** 312-733-2800.

Urology

Summer Clinical Series
For: Urologists. Caurse, July 30-31, Palmer House, Chicaga. **Sponsar:** American Uralagicol Assn., P. O. Bax 25147, Houston, TX 77265. **Reg. deadline:** 7/30. **Fee:** yes. **Reg. limit:** 200. **Credit:** Categary 1. **Cantact:** Alice Henderson. **Phane:** 713-790-6070.

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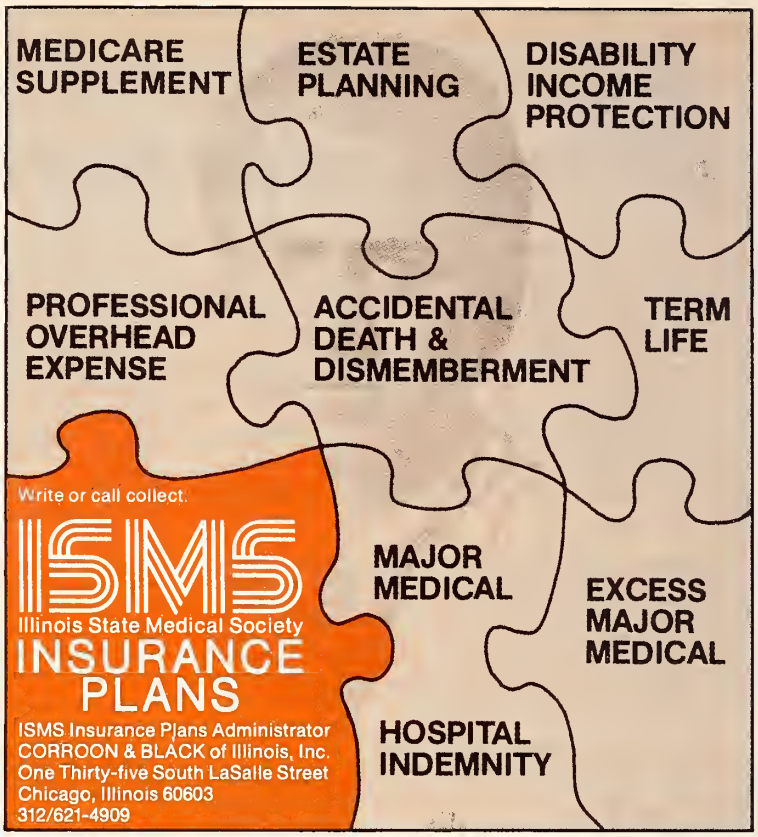
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President's Page



Medicine's Front Runners

The Positive Futurist

I recently met a self-identified positive futurist. He explained that futurists ride the crest of technical and social change. Negative futurists, he said, are prophets of doom and gloom. Positive futurists were defined as those who grasp the social and technical dynamic and mold it to their own purposes.

This positive futurist displayed many traits which physicians must acquire for the coming decades of health care delivery. It's not hard to see that the front runners in medicine will be those who adapt best to the changes presented.

It will be important for physicians to *forecast* and analyze the impact of anticipated events. It's been predicted that economic shifts will occur in three year intervals. He'll need to stay flexible, lean and efficient.

Each physician will need a *contingency plan,* analogous to the time-honored habit of considering the differential diagnosis when he problem-solves for his patients. Adjustment to a more competitive marketplace must be among his contingency plans. This will include significant interaction between government and industry to address the physician surplus.

The positive futurist MD will make efficient *blueprints* for quality medical care. Our organizational traditions will support local planning and—where necessary—a broader umbrella of planning services to meet the needs of smaller units.

Recognition of marketplace influences will have high priority in the positive futurist MD's blueprint. He'll find a way to accommodate to overall reduction in government spending and less first dollar health insurance coverage. He'll anticipate and plan for greater efforts by business to reduce their outlays as well as increased competition from hospitals for primary care patients.

Finally, as a positive futurist he'll anticipate a *reconfiguration* of his practice and the overall medical care delivery system. To meet these challenges head on, he'll seek to understand the changing environment, know and concentrate on his distinct competences, develop and focus on contingency plans, project future markets and mold his own future.

The positive futurist MD will learn to forecast events, plan for contingencies, prepare personal blueprints, anticipate a reconfiguration of medical practice and stay flexible. These skills will enable him or her to meet the challenges of medicine in the decades to come. ◀

Robert P. Johnson, M.D.

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An Historical Perspective

The pioneers who travelled Illinois' waterways encountered harsh conditions. These hard times brought a need for more and better medical care.

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The book reflects pioneer life, attitudes toward medical practice and the physician's place in the pioneer community. Crellin supplements his documentation with correspondence from physicians and patients in the area.

Medical Care In Pioneer Illinois is the third book in the Southern Illinois University's medical humanities series. The Illinois State Medical Society Educational and Scientific Foundation provided financial assistance in the book's publication.

Medical Care In Pioneer Illinois can be purchased by sending a check for $15.95 made payable to Southern Illinois Foundation to: The Pearson Museum, Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708.

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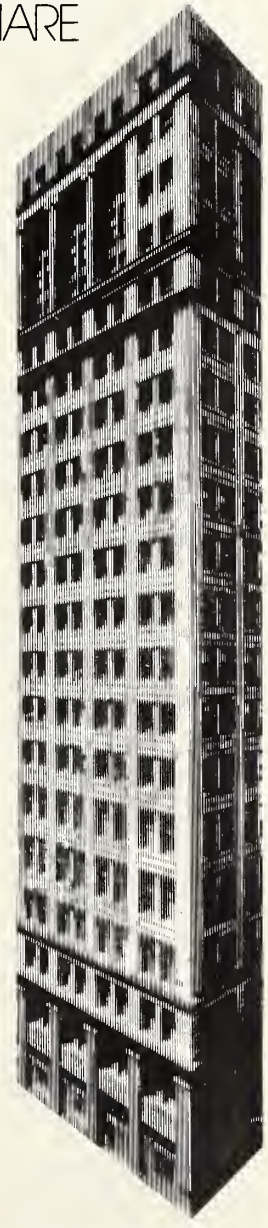
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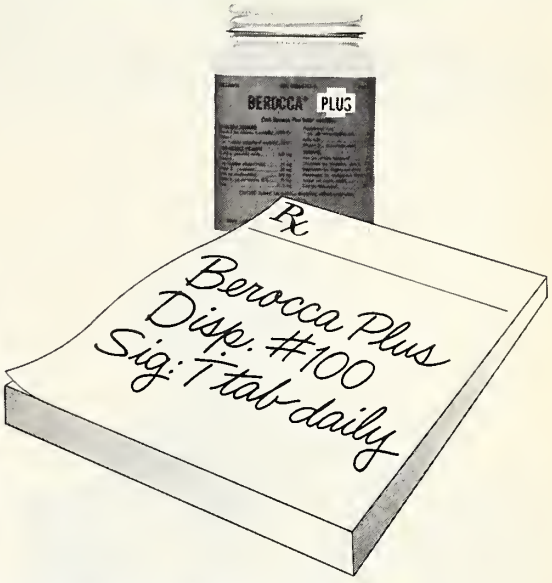
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Rx ONLY **Berocca® Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION



Before prescribing, please consult complete product information, a summary of which follows:
Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).
INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
CONTRAINDICATIONS: Hypersensitivity to any component.
WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient.* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.
HOW SUPPLIED: Golden yellow, capsule-shaped tablets — bottles of 100.

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5,000,000 hospital patients with infections.[1] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[2]



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...candidates for

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THE MULTIVITAMIN/MINERAL FORMULATION

1. Dixon RE: *Ann Intern Med 89*(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease,* edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1114.

Please see summary of product information on reverse page.

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., Dovid J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a 34 year old lady with a history of systemic lupus erythematosus (SLE) since age twenty-four. She developed renal failure secondary to SLE at age twenty-six years and was maintained on chronic hemodialysis. Her course on chronic hemodialysis was complicated by multiple arteriovenous fistula failures. She would be maintained on peritoneal dialysis during these periods. Two years ago she had a cadaver kidney transplant performed. She did well until two days prior to admission when she developed arthralgias, myalgias, and a fever of 104° F. She also complained of shaking chills, intermittent diarrhea and vomiting. There were no urinary tract symptoms. Her medications include azathioprine, prednisone, and folic acid. Her blood pressure was 100/60 with a pulse of 100 beats per minute. Heart and lungs were normal. A white blood cell count was 14,500 with 20 bands and 69 segmented neutrophils. Urinalysis showed 4+ blood, 1+ protein, and a gram stain with innumerable white blood cells and intercellular gram negative rods. Cultures were obtained and antibiotics were started. Her temperature and pulse rate decreased. This twelve lead ECG was obtained.



Questions:

1. The twelve lead ECG shows:
- a. Complete left bundle branch block.
- b. Severe left ventricular hypertrophy.
- c. Findings compatible with hyperkalemia.
- d. ST-T wave changes compatible with ischemia.
- e. Pre-excitation or Wolff-Parkinson-White (WPW) syndrome.

2. The clinical history and the ECG suggest which of the following statements is/are true?
- a. Severe electrolyte imbalance is present.
- b. Cadaver renal transplant rejection is occurring.
- c. The patient has developed silent coronary artery disease.
- d. None of the above.

(Continued on page 360)

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References: 1. Traub, Y. M., *et al.*: Clin. Pharmacol. Ther. *28*:765 (Dec.) 1980. 2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. *647* (Suppl.):67, 1981. 3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
Inderal® (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System:* lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

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—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).
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—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

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Store at room temperature (approximately 25° C).

INJECTABLE

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Pulse of the ISMS Auxiliary

Installation Address

By Susanne Webb, ISMSA President

The coming year, 1984, is going to be the year of the CAT in Illinois and we urge all doctors' spouses to "Choose Auxiliary Today" and join us in our stated goals. This year, we'll seek to improve the quality of life in our communities through volunteer efforts in health education and services and to promote mutual understanding among physicians' families.

My goal this year will be to preserve a continuity of programs in health projects, membership and legislation. Ongoing health projects programs are child seat belt safety, (which overlaps with legislative objectives) and education programs in nutrition, immunization, fetal alcohol syndrome, child abuse and drug abuse. We should continue and expand Operation PSST—the physician spouse support team—because being a member of a doctor's family is stressful.

In membership we should continue the club for new members, continue the work done with medical student and resident spouses and recruit members-at-large. The ISMS has an excellent governmental affairs section and we need to keep abreast of legislative developments and contact our legislators on bills of concern to medicine.

There are some important dates this coming year which I would like to mention:

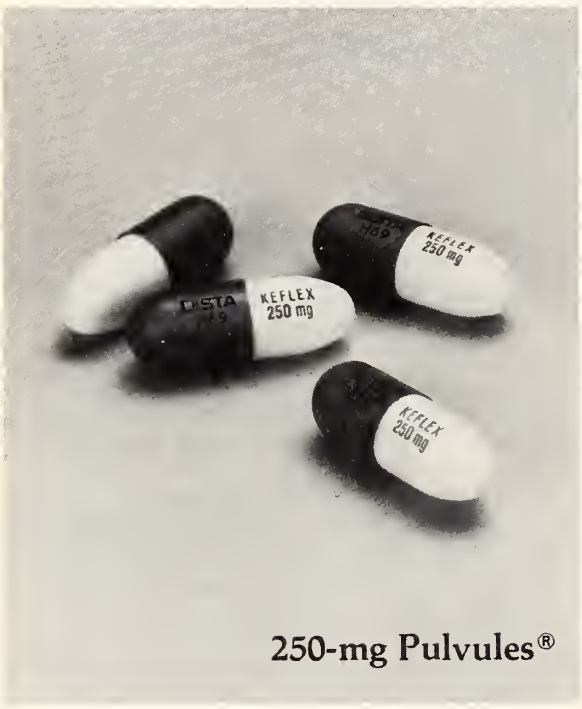
- *June 19-22* is the AMA Auxiliary annual meeting where your elected delegates will vote on the issues presented and hear reports on other states' activities.
- *Sept. 13, 14, & 15* will be the northern, central and southern state leadership seminars presenting ideas and information to be taken back to the counties.
- *Oct. 9-11* is the AMA Auxiliary Leadership Confluence where county presidents-elect receive leadership training and a generous dose of enthusiasm. It is essential to send our full complement.
- *Oct. 19* will be Fall Conference in Peoria with programs pertinent to our goals and to the ongoing AMA Auxiliary Shape Up For Life program with emphasis on the early, middle and later years.

You are the auxiliary. The state and national auxiliaries are not abstract entities but individual auxilians working together to provide leadership, share resource materials and coordinate programs.

As your president, I feel that visits to each county are most important because that's where the action is—where the work of auxiliary is done. I would strongly encourage you to use your state officers and chairmen in your programs, especially those who are geographically close or are in areas of particular interest to your county.

Please feel comfortable in calling or writing to me at any time. Let's keep the lines of communication not only open but active. ◀

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OBITUARIES

*__Brooks, Philip D.__, Rockford, died March 2, 1983 at the age of 57. Dr. Brooks was a 1952 graduate of the Northwestern University School of Medicine, Chicago.

**__Cantu, Samuel S.__, Chicago, died February 5, 1983 at the age of 79. Dr. Cantu was a 1927 graduate of the *Facultad de Medicina de la Universidad Nacional Automoma de Mexico,* Mexico.

*__Cortesi, Loli R.__, Villa Park, died March 4, 1983 at the age of 70. Dr. Cortesi was a 1937 graduate of Rush Medical College, Chicago.

**__Dragstedt, Carl A.__, Schaumburg, died March 8, 1983 at the age of 87. Dr. Dragstedt was a 1922 graduate of Rush Medical College, Chicago.

*__Fulcher, J. Hershel, Jr.__, Springfield, died March 11, 1983 at the age of 50. Dr. Fulcher was a 1958 graduate of the Emory University School of Medicine, Atlanta.

*__Kortemeier, Elwood F.__, Freeport, died February 26, 1983 at the age of 72. Dr. Kortemeier was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

**__Larrain, Abel R.__, Chicago, died February 11, 1983 at the age of 80. Dr. Larrain was a 1927 graduate of the University of Health Sciences, Chicago Medical School.

__Lukes, Steven A.__, Wilmette, died March 2, 1983 at the age of 31. Dr. Lukes was a 1977 graduate of the University of Illinois Pritzker School of Medicine, Chicago.

**__McNeal, Morley D.__, Deerfield, died March 7, 1983 at the age of 91. Dr. McNeal was a 1917 graduate of the Johns Hopkins University School of Medicine, Baltimore.

*__Ratko, Arthur L.__, Flossmoor, died March 29, 1983 at the age of 60. Dr. Ratko was a 1950 graduate of the Northwestern University Medical School, Chicago.

*__Rodal, Bruno__, San Diego, California, died January 7, 1983 at the age of 72. Dr. Rodal was a 1938 graduate of the *Deutsche Universitat Medizinische Fakultat,* Praha, Czechoslovakia.

**__Seltzer, Sam__, Chicago, died March 5, 1983 at the age of 84. Dr. Seltzer was a 1927 graduate of the Loyola University Stritch School of Medicine, Maywood.

__Summers, Anthony W.__, Oak Park, died March 6, 1983 at the age of 88.

**__Summerville, Milton J.__, Oak Park, died March 10, 1983 at the age of 84. Dr. Summerville was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of the Fifty Year Club*

The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,
Department of Radiology, Loyola University Stritch School of Medicine

This 40 year old woman has microscopic hematuria and a history of recurrent pyuria for more than one year. She had also had tuberculosis as a child. Her chest radiographs are nomal.



Figure 1
Excretory urogram. Close up of right kidney. There is narrowing of an infundibulum (open arrow) which was persistent. There is an abnormal linear collection of contrast material in a papilla of the upper pole (closed arrow).

Your diagnosis?

(1) Genitourinary tuberculosis
(2) Papillary necrosis
(3) Transitional cell carcinoma
(4) Brucellosis of kidney
(5) Radiation damage

(Continued on page 364)

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Brent M. Greenberg, M.D.
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Mark Greenberg, M.D.
Diplamate American Board of Radialogy

IMJ
Illinois Medical Journal
Volume 163, No. 5, May 1983

An Algorithmic Approach To Evaluate Pulmonary Masses

By Richard A. Mintzer, M.D., Robert Vogelzang, M.D., Harvey L. Neiman, M.D., Salvador R. Malave, Jr., M.D. and Thomas J. Egan, M.D./Chicago

Confusion among both radiologists and clinicians over appropriate sequencing of the radiologic and nonradiologic workup of pulmonary nodules has increased with the ever expanding number of diagnostic modalities available, including CT, 55° hilar tomography and transthoracic needle biopsy. We have developed an algorithm for the workup of pulmonary nodules which expedites the rapid and efficacious evaluation of pulmonary masses incorporating most of the current available techniques for workup of pulmonary disease. Fifty patients were included in the current study.

Solitary or multiple pulmonary parenchymal nodules continue to be a diagnostic dilemma. Radiologic evaluation of these nodules remains the mainstay of the diagnostic armamentarium. Appropriate radiologic examination can spare patients unnecessary hospitalization and reduce both duplication of imaging results, and the number of major and minor surgical procedures. Differentiation of benign from malignant processes as well as distinction of resectable from unresectable tumors can be accomplished by this approach.

To achieve these results the radiologist, as well as the clinician, must take an aggressive role. Appropriate use of both radiographic and nonradiographic procedures in these patients must be properly sequenced. Whenever possible, noninvasive procedures obtained on an outpatient basis should precede invasive procedures used to determine the pathologic process present in the lung parenchyma.

Any algorithm will reflect the availability of various diagnostic procedures at any particular institution and the biases and opinions of the clinicians and radiologists evaluating the patient. Further, the value of diagnostic procedures may vary widely from one institution to another. Our algorithm is a result of the opinions, biases and experiences of the clinicians and radiologists at our institution, as well as the excellence of our cytology.

Materials and Methods

Fifty patients seen in a five month period are included in this study. In assessing whether to enter an individual patient into our study, the high kv chest radiograph was analyzed along with the initial clinical information. The process was then categorized as having: (1) high probability of being benign; (2) an indeterminate appearance; or (3) an appearance with a high probability of malignancy. Only patients in the latter two categories were a part of this study. There were 13

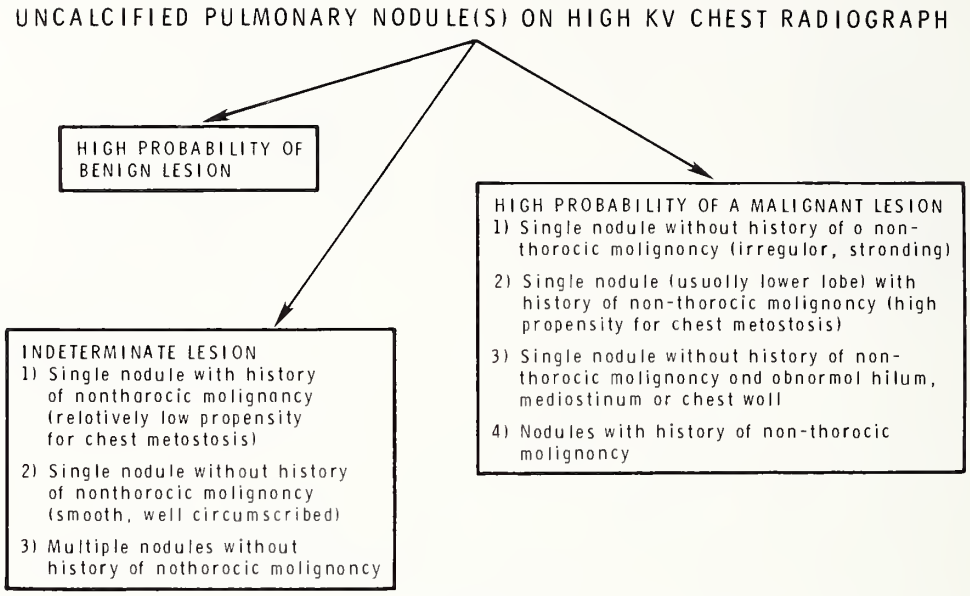


Figure 1
Classification of uncalcified pulmonary nodules on high kv chest radiographs.

patients who were classified as having indeterminate lesions and 37 patients in the high probability of malignancy category.

All patients had at least the "minimum" number and type of examinations prescribed in the algorithm.

In all patients the nodule or nodules demonstrated on the radiograph were a new finding (*i.e.*, either old chest radiographs were normal or previous chest radiographs were not available for comparison when the patient initially entered the study). No patients are included in this series with a high probability of a benign process based upon the patient's clinical status and the appearance of the lesion on a high kv chest radiograph.

In 49 of these cases a single pathologic process or an anatomical variant of normal was proven to be responsible for the pulmonary nodule or nodules. In one patient two distinct pathologic processes were responsible for two distinct pulmonary nodular densities. Forty-three patients had pathologic processes or anatomical normal variance primary to the lung parenchyma or pleura. Seven patients ultimately proved to have one or more metastatic deposits in the lung.

In all instances, a thoracic surgeon or a pulmonary disease physician from the department of medicine was either the primary care physician or an active consultant. Radiographic imaging modalities utilized in the algorithmic approach

HIGH PROBABILITY OF A BENIGN LESION

1) Potient less than or equol to 30 years of age
2) No history of previous molignancy
3) Potient osymptomotic (related to chest)
4) Lesion present ond unchonged in oppeorance for more than or equol to 2 yeors.
5) Clossic benign chorocteristics (colcificotions, sotellite nodules, etc.) Colcificotions-diffuse, stippled, ringlike, concentric.

Only need to periodicolly observe (re-evoluote) every six months for 2 yeors.

Figure 2
Criteria for lesions having a high probability of being benign.

included: low kv chest radiographs, conventional tomography of the pulmonary nodule, conventional hilar tomography, conventional mediastinal tomography, whole lung tomography, and chest CT. Other diagnostic modalities utilized in the algorithm included fluoroscopic guided transthoracic needle biopsy (TTNB), fiberoptic bronchoscopy (usually with bronchial biopsy or bronchial brushing), mediastinoscopy, mediastinotomy and diagnostic thoracotomy.

Low kv chest radiographs were obtained on a Picker automatic chest unit with phototiming utilizing 66 to 70kv. When necessary, tomo-

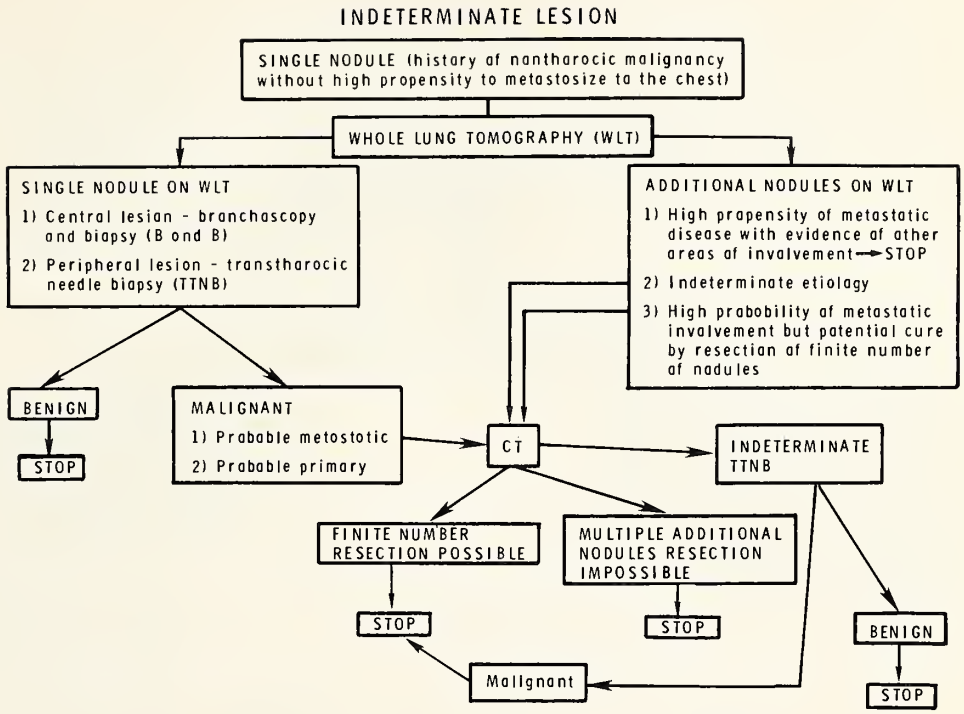


Figure 3a
Criteria for an indeterminate lesion: (a) sequential staging of a solitary pulmonary nodule in patients with proven nonthoracic malignancy.

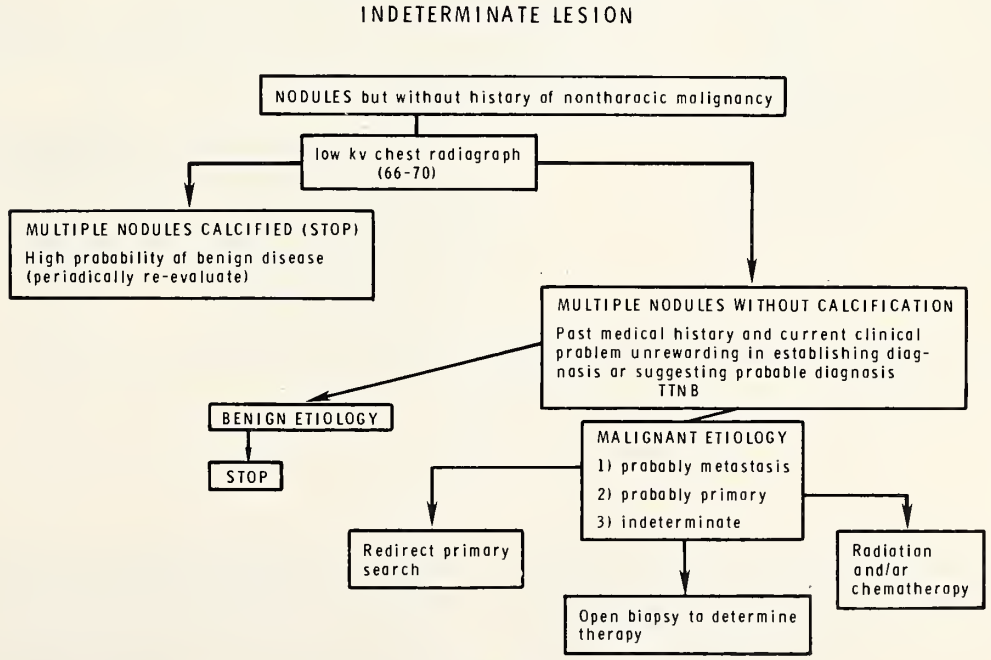


Figure 3b
Criteria for an indeterminate lesion: (b) sequential staging of multiple pulmonary nodules in patients without previous nonthoracic malignancy.

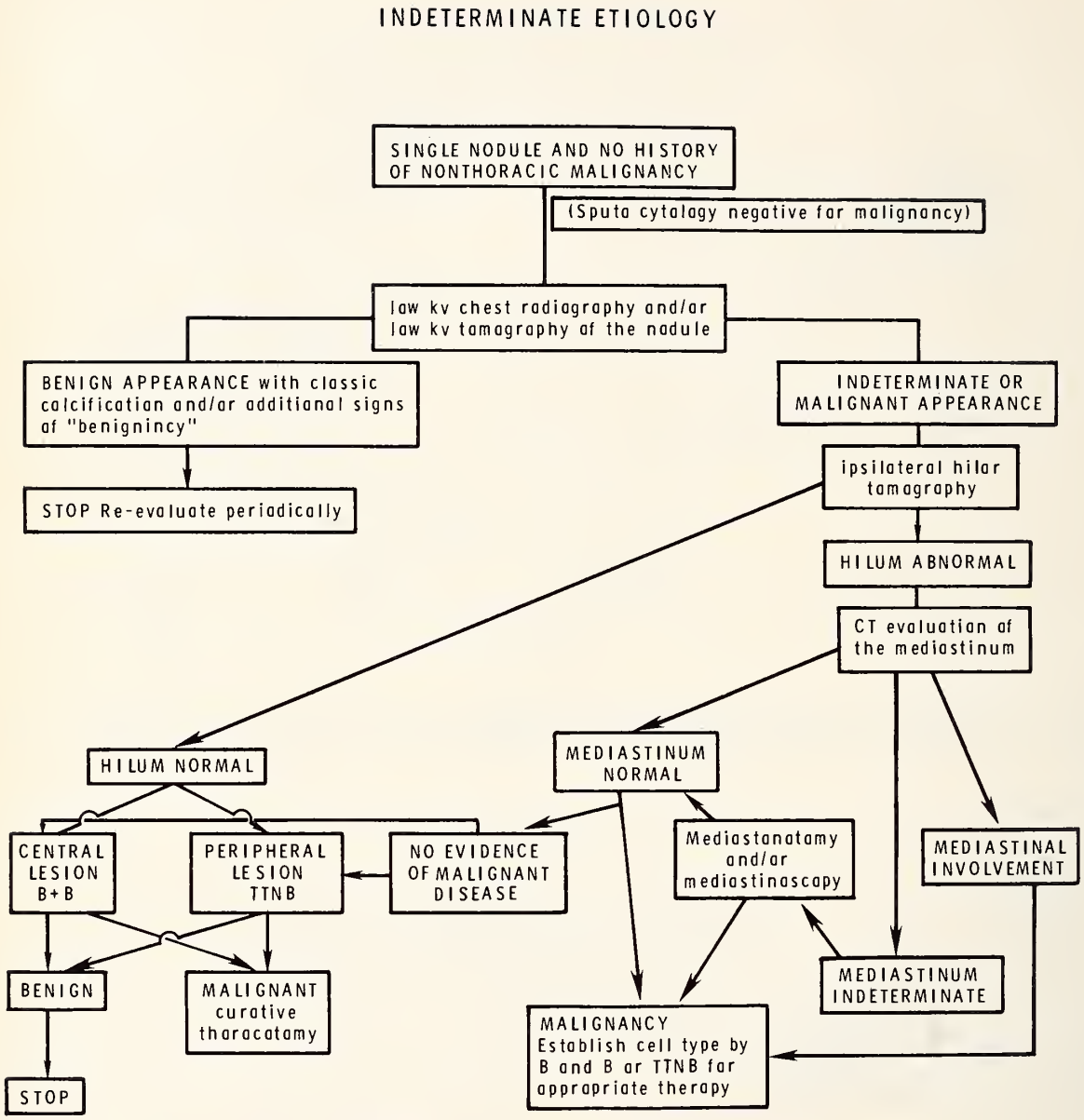


Figure 3c

Criteria for an indeterminate lesion: (c) sequential staging of a solitary pulmonary nodule without history or previous nonthoracic malignancy.

graphic evaluation of pulmonary parenchymal processes included low kv (66 to 70kv), thin section (50° arc), small focal spot (0.3mm) tomographic technique. When the hila were evaluated, both AP and 55° oblique tomography in the conventional manner utilizing 82 to 90kv were obtained.[1-3] Mediastinal and whole lung tomography were also made in the conventional manner utilizing high kv and a trough filter.[4] All tomographic studies were obtained on a Philips polytome unit and all procedures were physician-monitored.

Thoracic CT scans were performed with an EMI 5005 scanner.[4] All scans were done with infusion. Whenever possible, examinations were performed in suspended respiration. All CT procedures were physician-monitored and appro-

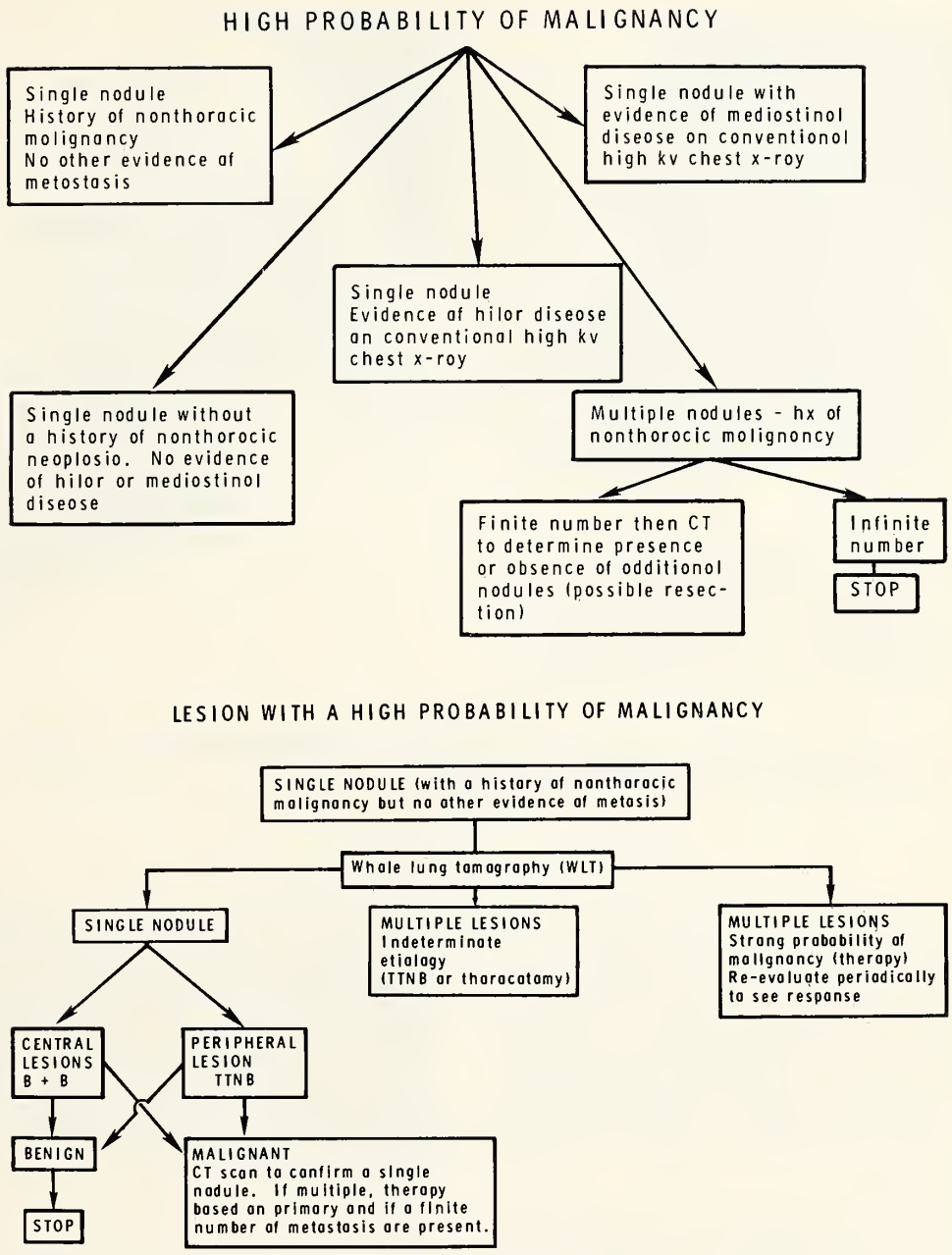


Figure 4a
Criteria for probable malignant solitary pulmonary nodule(s): (a) Sequential staging of a single nodule in patients with a history of nonthoracic malignancy but no other evidence of metastasis.

priate scan levels, window widths, and window levels were obtained.

The chiba "skinny" needle was used for all fluoroscope-guided transthoracic needle biopsies. Usually, two or three aspirations were performed. The tissue was immediately examined and if the aspirations were not diagnostic as many as three additional aspirations were made. The tissue was then sent to the cytopathologic laboratory for complete evaluation. In addition to cytologic examination, cultures and stains were obtained when appropriate.

Mediastinoscopy, mediastinotomy, and diagnostic thoracotomy were performed in the con-

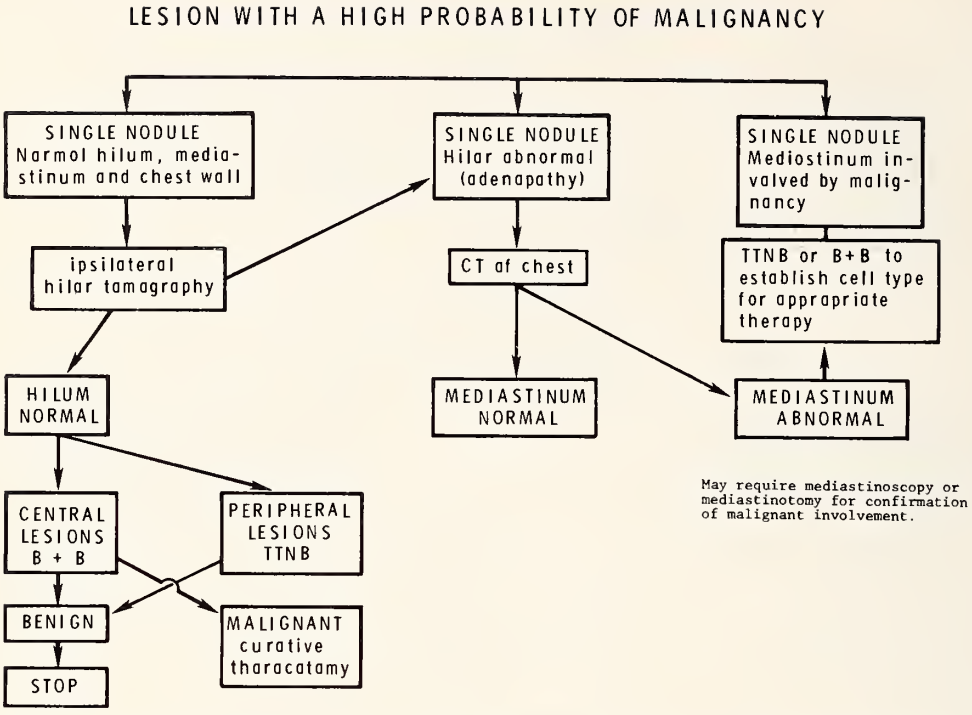


Figure 4b
Criteria for probable malignant solitary pulmonary nodule(s): (b) Sequential staging of solitary pulmonary nodule in patients with a high probability of malignancy.

ventional manner. Mediastinoscopy is an endoscopic procedure performed through a small incision in the suprasternal notch, generally used when evaluation of right sided disease is required. This procedure is inappropriate for visualizing the anterior nodal group of the left chest, the aortic window area, or the subcarinal nodes. Patients requiring examination of the left mediastinum and the AP window required mediastinotomy.

As stated earlier, patients were classified as having benign, indeterminate, or probable malignant processes. (Fig. 1) Only the latter two categories are included in this study. (See Fig. 2 for criteria of "benignancy".) Patients with lesions of indeterminate etiology (Fig. 3) had chest radiographs demonstrating a single nodule with a history of a nonthoracic malignancy with a low propensity for chest metastasis (Fig. 3A), multiple nodules with no history of nonthoracic malignancy (Fig. 3B), or a single nodule with a history of nonthoracic malignancy and smooth discrete borders, but no calcification (Fig. 3C).

The group of patients with a probable malignancy included those with a single nodule and a history of nonthoracic malignancy with a high propensity for chest metastasis (Fig. 4A). Shown in Figure 4B are a single nodule without a history of nonthoracic malignancy but a "malignant appearance," a single nodule with no history of nonthoracic malignancy but an abnormality of hilum, mediastinum, or chest wall and multiple nodules in the patient with a history of nonthoracic malignancy.

Results

Thirteen patients (26%) had pulmonary processes classified as indeterminate. (Table I) Ten of these indeterminate lesions ultimately proved to be benign processes. (Table II) The three indeterminate nodules which were malignant in origin were two primary peripheral adenocarcinomas, and a solitary metastatic deposit from a cervical carcinoma. Frequently, the benign character of the process could be determined without hospitalization by immediately performing low kv chest radiographs and/or a low kv chest tomogram. This occurred in five of the patients. (Fig. 5) Thus, five (38%) of the patients with indeter-

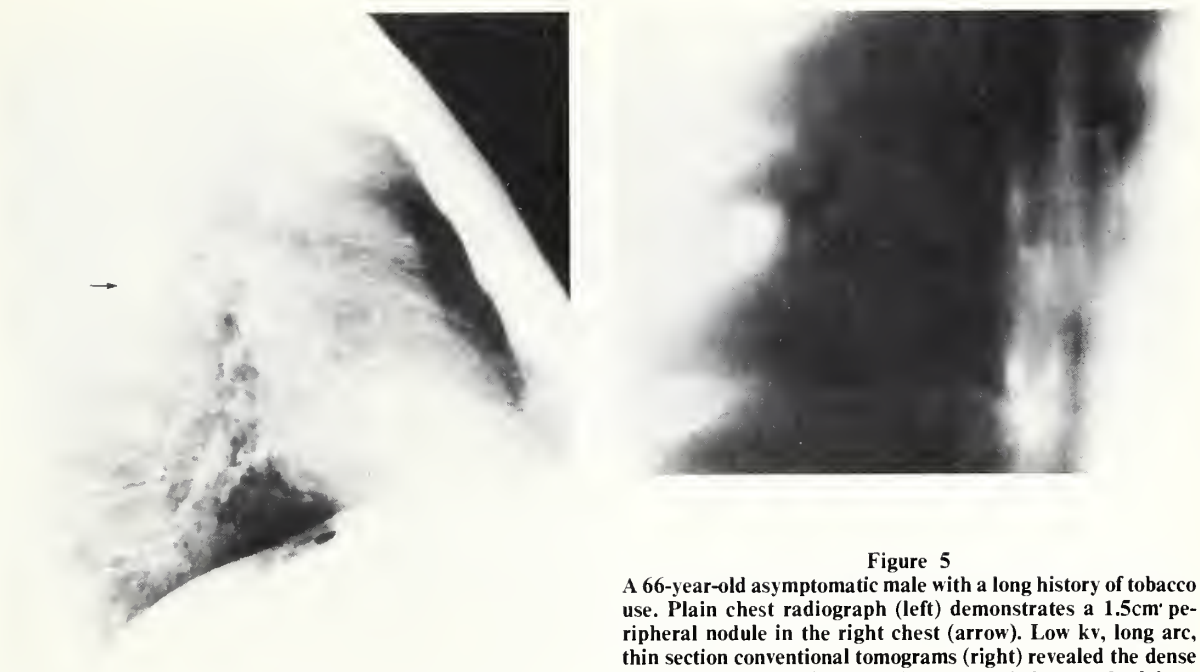


Figure 5
A 66-year-old asymptomatic male with a long history of tobacco use. Plain chest radiograph (left) demonstrates a 1.5cm peripheral nodule in the right chest (arrow). Low kv, long arc, thin section conventional tomograms (right) revealed the dense central nidus of calcium and the concentric layers of calcium.

Table I
Radiologic-Pathologic Correlation of Processes

Radiographic Appearance (on high kv chest radiographs)		*Pathologic Diagnosis*
Indeterminate Lesions (13)		
1) Single nodule with history of nonthoracic malignancy with low propensity to metastasize to the chest.	(3)	(10) proven benign (3) proven malignant
2) Single nodule and no history of nonthoracic malignancy.	(9)	
3) Nodules with no history of nonthoracic malignancy	(1)	
Malignant Appearance (37)		
1) Single nodule with a malignant appearance.	(17)	(8) proven benign* (30) proven malignant
2) Single nodule with a history of nonthoracic malignancy with high propensity to metastasize to the chest.	(3)	
3) Single nodule with no history but abnormal hilum, mediastinum or chest wall.	(8)	
4) Nodules and nonthoracic malignancy	(9)	

**1 patient had both a primary lung tumor (adenocarcinoma) and a benign process hamartoma*

minate lesions were spared any hospitalization time.

At admission, the remaining eight patients with indeterminate processes already had their nodule evaluated by conventional tomography and could immediately proceed to whole lung tomography and/or hilar tomography and/or interventional procedures. These procedures could be scheduled in advance and a tissue diagnosis could usually be established within three days of hospitalization. Definitive therapy still might be delayed several days for a complete preoperative evaluation.

Thirty of the 37 patients with malignant appearing nodules were ultimately proven to have either a primary malignancy or a metastatic process in the lung parenchyma. (Table I) One of these patients had both a malignant process (a primary adenocarcinoma) and a benign process (hamartoma) in the left upper lung field. (Fig. 6) Five

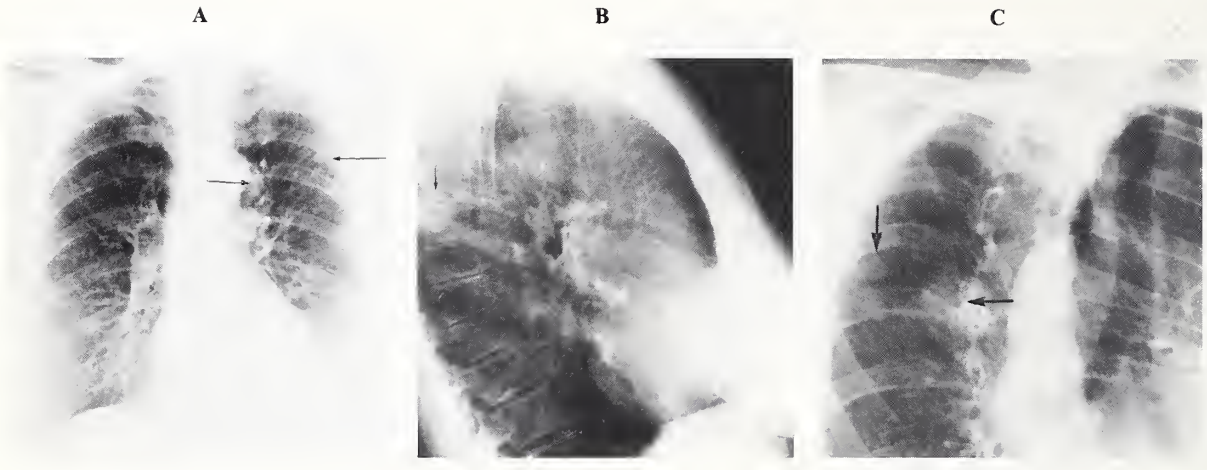


Figure 6

A 63-year-old asymptomatic female, long time cigarette smoker (greater than 40 pack years) with two nodules seen in routine radiographs in the left upper lung field (A & B). A right anterior oblique radiograph (C) demonstrates more clearly the relative positions of the two nodules (arrows). Transthoracic needle biopsy revealed adenocarcinomas in the larger lesion. After an exhaustive workup failed to reveal another source of malignancy, the patient underwent a thoracotomy. The larger lesion was a primary adenocarcinoma, the smaller lesion proved to be a hamartoma.

of the remaining seven patients had pathologically proven benign processes. Three of these lesions ultimately proved to be granulomata and one of the lesions was a hamartoma. Round atelectasis and pleural plaques in a patient with a history of asbestosis were responsible for the final pathologically proven process. Two patients were presumed to have old granulomatous disease because of the eventual procurement of old films. These old films confirmed the presence of the process unchanged for greater than two years.

The malignancies included 26 primary tumors (Fig. 7) and seven metastatic deposits. (Table II) There were eight squamous cell and eight adenocarcinomas. Four small cell carcinomas and four undifferentiated carcinomas, as well as two large cell carcinomas accounted for all the malignant primary lesions. Metastatic deposits were from the genitourinary tract in five of the seven secondary deposits. The only nongenitourinary metastases were from the colon and from a chondrosarcoma.

In this group of patients, as in the indeterminate group, preadmission testing and early scheduling of procedures resulted in pathologic diagnosis within a few days. Definitive therapy began shortly thereafter.

Discussion

Our analysis of cases in this series suggests that an algorithmic (*i.e.*, sequenced) approach to chest masses expedites the rapid and efficacious workup of solitary or multiple pulmonary nodules through a combination of radiologic and nonradiologic testing. However complex schema and testing may become, routine PA and left lateral chest Xray remain the firm foundation on which rests all screening and preliminary categorization of lesions. To emphasize this obvious but sometimes ignored fact, we briefly examined error rates for malignant and benign lesions as seen in this study.

Malignant criteria outlined in the literature[5,7] include lesions greater than 4cm. in size, lesions crossing a fissure, having ill-defined lobulated or umbilicated borders and/or a corona radiata. In addition, the peripheral cavitation with bulging outer borders has been used to describe lesions which are probably malignant.[7] In this study, we found size of lesion, presence of nonthoracic malignancy and absence of calcification to be the most consistent indicators of the malignancy.

Of the patients with malignant appearing lesions, 30 of 37 proved to have malignancy and seven were proven to have benign lesions. In the malignant category this should indicate approximately 80% accuracy in initial screening. As a preliminary stop in the flow chart, such a division is both highly useful and accurate and hopefully speeds the arrival of a decision for or against surgical cure.

Classically described signs of "benignancy" have included calcification[6] which is either diffuse, stippled, ring-like, or concentric as well as localized or segmental bronchiectasis[8] and "satellite" lesions. Even in the absence of so called classic calcification, any calcification in a nodule

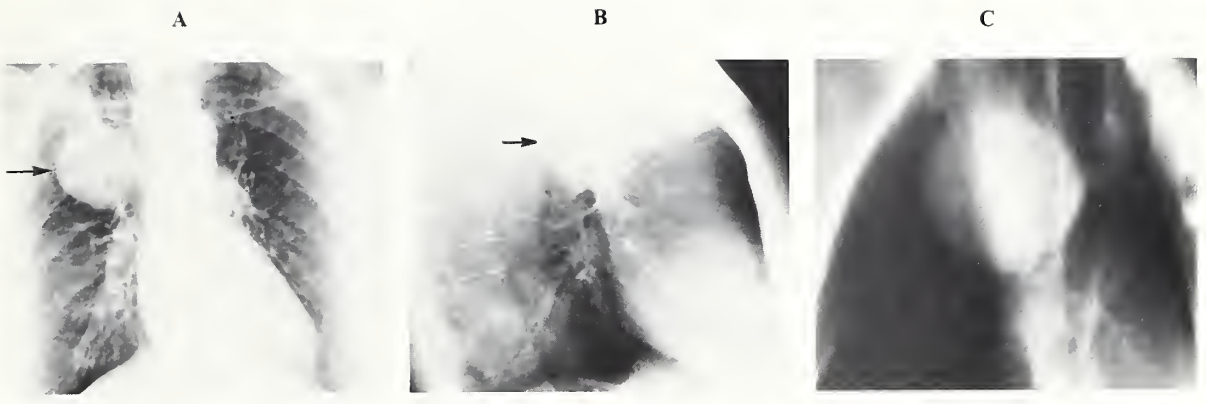


Figure 7
A 68-year-old female with acute onset of hemoptysis. A 5 cm. mass is seen on the routine radiographs (A & B) in the right upper lobe (arrows). The hilum was normal (C) on tomography. Because the mass was in close approximation with the superior aspect of the right mediastinum, a CT scan was obtained after bronchoscopy and biopsy revealed adenocarcinoma. The CT scan was reported as normal and curative resection was undertaken. At thoracotomy no mediastinal disease was present.

Table II
Distribution of Lesions
50 cases (51 proven pathologic lesions)

Benign Lesions (18 total)		
proven benign*	12	(pathological proof)
strong presumption	6	(classic benign calcification, etc.)
**Distribution of Benign Lesions*		
proven infection	7	
proven benign tumor	2	
proven anatomic variant	2	
proven pleural plaque	1	
Malignant Lesions (33 total)		
proven malignancies	33	
Distribution of Malignant Lesions		
Primary Malignancies	26	
squamous cell carcinoma	8	
adenocarcinoma	8	
small cell carcinoma	4	
undifferentiated carcinoma	4	
large cell carcinoma	2	
Metastatic Lesions (7 total)		
prostatic adenocarcinoma	1	
chondrosarcoma	1	
cervical carcinoma	1	
renal cell carcinoma	1	
choriocarcinoma	2	
colon carcinoma	1	

indicates that it is probably benign.[9] Size, presence of other malignancy and calcification were again most consistently helpful as preliminary screening indicators in this study. Conclusively benign lesions as seen on initial chest X-ray screening were not included in this study since these present no real diagnostic dilemma for the radiologist.

Of the patients with indeterminate appearing lesions (13 cases), 10 were proven to be benign and three malignant. Since most obvious malignancies have been screened by the probably malignant category, it would be expected that the indeterminate category would have a high percentage of benign lesions, as is the case here. Again, this seems to achieve a good initial division of cases for future workup. It must be stated that without "pathognomonic" signs of benignancy (*e.g.*, central or dense calcification or no

change for two years) tissue diagnosis is a necessity for absolute confirmation.

Obviously, the development of any algorithm reflects individual and institutional biases, opinions, and availability of facilities. Ours is certainly no exception. Bronchoscopy and bronchial brushing, TTNB and subsequent cytopathologic examination of the cells is the cornerstone of the decision tree we present here. Understandably, excellence in cytology is a prerequisite for a scheme such as ours. Other institutions without high quality cytopathologic assistance may reflect a bias toward open biopsy, for example.

Our algorithm accomplished most of the goals for which it was designed. First, it efficiently divided patients into broad categories for further proper and rapid evaluation. Second, it "ordered" the diagnostic testing such that pre-admission testing was maximized and post-admission workup was expedited. Third, it succeeded in (1) decreasing duplicated or nonproductive tests; (2) decreasing hospital admission; (3) decreasing hospital days per admission; (4) decreasing invasive procedures; and (5) eliminating "curative" thoracotomy for noncurable disease. It should be noted that the current study is not large enough to draw final conclusions at present. The study is continuing and will include 300 patients in the final analysis.

Not all modalities or controversies have been considered here. Currently, we are prospectively analyzing the inclusion of Gallium 67 citrate scanning as part of the diagnostic workup of intrathoracic malignancy. Also the question of TTNB vs. bronchoscopy and biopsy has not been analyzed in this report. Rather, both modalities were utilized by depending on location of the lesion (central vs. peripheral) and were considered complementary rather than competitive.

Conclusions

The algorithm which we present here is effective in reducing duplicated testing, reducing hospital time and facilitating the rapid radiologic and nonradiologic workup of intrathoracic masses. Advanced preparation is important in implementing this algorithm. That is, cooperation between clinician, radiologist, and pathologist is vital if the workup is to be accomplished smoothly and rapidly. Routine and PA left lateral chest X-ray remains an excellent screening and diagnostic tool. Our series of 50 cases is admittedly small and will continue up to a maximum of 300 patients. Gallium scanning will also be considered in future studies. ◀

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This fascinating exhibit will be on display for a limited time only. The Chicago Medical Society extends an invitation for all to come and enjoy the exhibit.

Case Reports

Torsade de Pointes

By Tien C. Cheng, M.D./Waukegan

The advent of coronary care units has helped us to identify malignant ventricular arrhythmias. The ventricular tachycardia has been defined as three or more consecutive ventricular premature contractions. Not all ventricular tachycardias degenerate into ventricular fibrillation and flutter and lead to cardiac death. The recognition of one form, Torsades de Pointes, is very important and requires immediate external cardioversion to save the patient's life.

An 85 year old male was brought to the emergency room after he passed out in a restaurant. The witness stated that before he lost consciousness he complained of severe chest pain. There was no evidence that he had difficulty swallowing before the attack.

On examination, he was alert. Blood pressure was 120/70 mmHg. Respiratory rate was 20 per minute. On room air, his pO_2 was 101, pCO_2 39, pH 7.43, bicarbonate 26. Chest X-ray showed cardiomegaly but no evidence of active infiltrate or pulmonary congestion. Electrocardiogram revealed atrial fibrillation with a moderate ventricular response and frequent premature ventricular beats with occasional short bursts of ventricular tachycardias. The QT interval was prolonged at 0.50 seconds. He was quickly admitted to the coronary care unit for monitoring. Two hours later, one episode of ventricular tachycardia degenerated into ventricular flutter and fibrillation (Figure 1) and the patient was immediately cardioverted. Recurrent ventricular tachycardias, 8-10 beats in succession, became a problem despite lidocaine bolus injections and lidocaine 4.0mg per minute continuous drip. The medication was changed to bretylium tosylate at a dosage of 4.0mg per minute continuous drip, but this still did not control the frequent premature ventricular beats. In addition, frequent episodes of high degree AV block with a ventricular response of 30-40 per minute were seen and these seemed to precipitate more bouts of ventricular tachycardias.

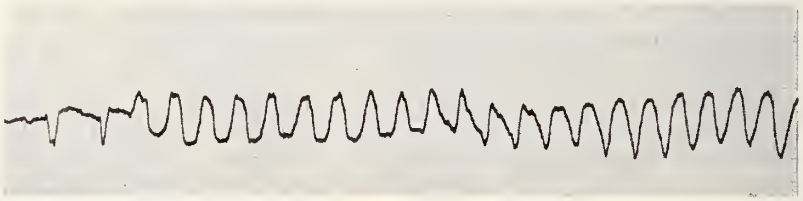
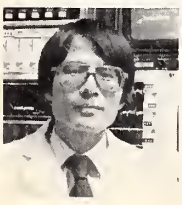


Figure 1
Monitor strip showing sinus rhythm interrupted by fast ventricular tachycardia which is succeeded by a run of wide QRS tachycardia with opposite axis in an undulating fashion.

The patient had been taking procainamide 500mg orally every six hours; quinidine sulfate 300mg orally every six hours; digoxin 0.25mg orally every day; furosemide 40mg orally once a day and a potassium supplement. The admission serum digoxin level was 1.5 ng/ml and the serum potassium was 3.7mEq/L. Clacium was 5.0mEq/L, magnesium was 1.5mEq/L. His blood sugar was 100mg%, BUN was 29, creatinine was 1.7.

Because of failure to suppress frequent recurrent ventricular tachycardias and the intermittent high grade AV block, a temporary transvenous pacemaker was inserted and set at a rate of 80 per minute, demand function. This appeared to supress the premature ventricular beats adequately.

Four hours later, one episode of ventricular tachycardia degenerated into ventricular fibrillation (Figure 2) and an immediate precordial thump restored the basic atrial fibrillation. Intravenous potassium 10mEq per hour times three hours and phenytoin 250mg intramuscularly were given which practically eliminated all the premature ven-



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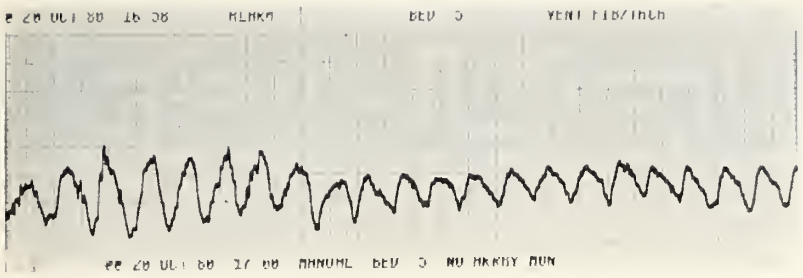


Figure 2
Same ECG characteristics, wide QRS tachycardia in undulating fashion with different axis.

tricular beats.

The thyroid was not enlarged and there was no bruit heard. The carotid arteries showed no bruit and had diminished arterial upstrokes. The lungs were clear to auscultation and percussion. The cardiac examination showed a very quiet apical impulse. The heart sounds were distant. When he sat up and leaned forward there was a G 2/6 ejection systolic murmur heard at the apex. There was no click or gallop. The abdomen was soft without abnormal mass. The bowel sounds were normal. The extremities showed no edema.

The remaining hospital course was uneventful. The bretylium tosylate, intramuscular dilantin and intravenous potassium were discontinued in two days. The temporary pacemaker was removed in three days and the patient was discharged home in fair condition. He was given dilantin 100 mg orally three times a day and digoxin 0.25mg orally once a day. When last seen (two months later) he was doing well.

Discussion

Torsade de Pointes is an electrocardiographic diagnosis which features paroxysms of ventricular tachycardia in which the QRS axis undulates over runs of 5-20 beats with definite changes in direction.[1] These electrocardiographic changes have been recognized since 1923[2] and have been titled repetitive paroxysmal tachycardia,[2] cardiac ballet,[3] and torsade de pointes.[4] The predominant underlying electrocardiographic abnormality is prolongation of the QT interval which favors the desynchronization of cardiac activation.[5] Causes which have been described include atrioventricular block,[6] hypokalemia,[7] hypomagnesemia,[8] surdocardiac syndrome (congenital deaf-mutism and QT prolongation),[9] quinidine, disopyramide,[10] psychotropic drugs, cardiac ischemia, myocarditis, possible prolapse of mitral valve[11] and drug interaction between amiodarone and quinidine.[12]

The patient described in this case had an acceptable serum digoxin level and seemed unlikely to have digitalis excess or intoxication. He had normal serum calcium, magnesium and near normal potassium. The fact that he had been taking procainamide could have conceivably made him vulnerable to QT prolongation and develop malignant ventricular tachycardia to account for his syncopal episode in the restaurant. Procainamide was discontinued promptly following the admission but he continued to have frequent ventricular irritability which was not controlled by lidocaine or bretylium tosylate.

When a temporary transvenous pacemaker was inserted to prevent further ventricular arrhythmia and high degree AV block, again he developed another episode. It was not until intravenous potassium infusion and intramuscular dilantin injection were given that torsade de pointes ceased.

We present this case to illustrate the importance of quick recognition of torsade de pointes which could well be what Wiggers[13] described in 1940 as a prelude to ventricular fibrillation. When the patient responds to cardioversion an aggressive approach in solving the underlying medical problem is a must. Quinidine-like drugs have to be discontinued. Dipheynylhydantoin and propranolol may be tried because of their beneficial effects of shortening the QT intervals. Temporary pacing is also indicated when high grade AV block appears.

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Surgical Grand Rounds

John M. Beal, M.D. and Julius Conn, Jr., M.D., Contributing Editors

Surgical Grand Rounds are held weekly on Tuesday at 5:00pm in the Offield Auditorium of the Passavant Pavilion of the Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 5, 1981.

Prophylactic Mastectomy And Reconstruction

Dr. Diane Gerber: A 35-year-old white woman was admitted to the Northwestern Memorial Hospital with a six year history of fibrocystic disease of the breasts. During this time, she had multiple cyst aspirations and open breast biopsies. A mammogram was consistent with fibrocystic disease. Of note was a family history strongly positive for carcinoma of the breast. Her mother had died of breast carcinoma. A sister developed carcinoma of the breast with bone metastasis when she was 26 years old. She had four maternal aunts and a maternal cousin, all of whom died of breast cancer. She was admitted to the hospital for prophylactic mastectomy. Her past medical history was positive for chronic sinusitis.

Physical examination revealed a well-developed, well-nourished white woman. The head and neck examination was normal. Lungs were clear and the heart examination was unremarkable. Breasts were large with multiple cystic masses bilaterally, particularly the upper, outer quadrants. Nipple discharge and tenderness were absent. The day after admission, the patient underwent bilateral simple mastectomies. At the same operative procedure, immediate breast reconstruction was performed, using bilateral subpectoral implants. The pectoralis major muscles were undermined to the level of the clavicle and to the mid-sternal area. Then 170cc silicone prostheses were placed under the pectoralis major muscles. The wounds healed without incident.

Dr. John M. Beal: As Dr. Gerber mentioned, at the time of the operation, our team performed bilateral simple mastectomies. An elliptical incision was made including both nipples so that we were certain all breast tissue was removed. After we had completed the mastectomies, Dr. Norman Hugo and his team performed the reconstruction. Our plan was to be as certain as possible that we performed a complete mastectomy and not to be influenced by the planned reconstruction. We think the final results were very acceptable from the standpoint of the husband's response, which was very important to the patient.

Dr. Ryiochi Oyasu (Pathology): As Dr. Beal mentioned, we received tissue specimens representing both breasts from simple mastectomies, which on cross section, revealed multiple cysts which ranged in size from 1 to 1½cm. Otherwise, the breast tissue was unremarkable. Grossly recognizable nodule or solid masses were absent.

Fibrocystic disease involves the structure inside the lobule which is the terminal portion of the breast tissue. The change most commonly seen is apocrine metaplasia of the terminal duct which shows cystic dilatations, and was found in this patient. Another histologic change we often see that was detected was an intraluminal growth of the lining cells, called papillomatosis. This was characterized by tongue-like projections to fill the terminal duct. An intraductal papillary growth was sectioned from a major duct, obtained from the tissue right beneath the right nipple, a typical intraductal papilloma. The changes were multifocal but benign. In some areas, one sees the early stages of intraluminal papillary growth and terminal duct epithelial hyperplasia, a common feature associated with chronic cystic mastitis or fibrocystic disease. In adjacent areas, there is a marked epithelial cell proliferation. The patho-

logical diagnosis is fibrocystic disease with papillomotosis.

Dr. Merrill Kies: This patient represents a very interesting case. She is not the typical young woman who comes to the medical oncology clinic with cancer phobia. She had an extraordinary family history, involving six of her maternal relatives with premenopausal breast cancer. The concept of familial breast cancer or the cancer family syndrome is complex. In some patients, multiple primary cancers may exist in the same organ or in multiple organs. When a patient comes to our clinic with a family history of premenopausal breast cancer, especially if the disease is bilateral, a very careful family history is obtained for the obvious reason that other individuals in the same family may require therapy. It appears, although it has not been conclusively shown, that males transmit the disorder.

In breast cancer, in particular, an association exists with ovarian cancer and, in fact, this turned out to be true with the patient we are discussing today. Once the history has been identified, a decision has to be made. We studied this patient for several months before recommending an elective bilateral mastectomy to her. We recognize that premenopausal breast disease, especially bilaterally, carries with it a relatively high risk. However in a 25 or 30 year old, the actual risk of breast cancer is low. Lynch has studied approximately 90 pedigrees of breast cancer families over a period of years and found breast cancer in association with ovarian cancer or other malignancies. The patient under discussion was 35 years old. One sister was 26 when she developed breast cancer, and her mother was 42 when she developed breast cancer. We can estimate that our patient's risk of developing breast cancer was not less than 20-25%. An independent observer from the National Cancer Institute estimated 25% for this individual patient at the patient's present age of 35 and 40.

Several considerations, I feel, are of the utmost importance. Before suggesting elective mastectomy in this case, the family's pattern, the patient's history, tests, operations, and tissue reports were reviewed. In addition to her strong family history, the patient had established bilateral cystic mastitis and this supported the concept of mastectomy. The patient and her husband were very carefully assessed and counselled. They were informed that it was possible that carcinoma might be found in the specimen removed for "prevention of cancer." One cannot overemphasize the importance of making sure the husband and patient understand the possibilities that there are operative risks and complications. The patient was also advised to obtain an opinion from another qualified surgeon.

Alternate Surgical Techniques

Dr. Norman Hugo: Selection of a technique for elective mastectomy involves two choices. One may either perform a subcutaneous mastectomy or a simple mastectomy. Subcutaneous mastectomy was performed approximately 100 years ago, then declined in use, and became popular again some 15 years ago. The object of subcutaneous mastectomy is to protect the high risk patient from development of carcinoma and to achieve a satisfactory aesthetic result. With long follow-up, subcutaneous mastectomy began to fail. There have been several reports of carcinoma appearing in the treated breasts after subcutaneous mastectomy, usually in the tail of Spence. To accomplish a subcutaneous mastectomy, the surgeon leaves tissue beneath the nipple. While this is not the most frequent site of carcinoma of the breast, it can develop there. The development of very thin skin flaps has been utilized to be certain that breast tissue does not remain. However, this increases post-operative morbidity. Thin skin flaps predispose to lack of good blood supply to the cutaneous envelope. This may result in infection, skin necrosis, or dehiscence of the wound. Another inherent complication is the placement of the prosthesis just under the skin in an extraordinarily large envelope. A potential hazard is that an average sized breast may have a cutaneous envelope which may increase the size of the reconstructed breast. Later, the skin contracts and continues to contract. It sometimes contracts to the point where a breast which was initially the size of a cantaloupe shrinks to the size of a tennis ball. The end result may be poor. In order to overcome this problem, the prosthesis is placed beneath the pectoralis and it is necessary to raise a portion of the superior portion of the rectus abdominus muscle to obtain a continuous muscle pocket. A suitably sized prosthesis is selected and there is no need for extra skin.

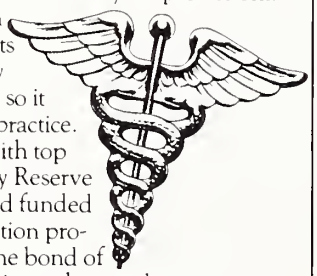
In my mind, there is no real advantage for preservation of the nipple. The performance of a subcutaneous mastectomy through an inframammary incision makes it very difficult to remove the tail of Spence, the portion of the breast where carcinoma has been reported most frequently after this procedure. These considerations support the use of simple mastectomy. A subpectoralis-rectus prosthetic implant can then be employed. To my knowledge, this procedure has only had one case of subsequent carcinoma, reported in 1969. I know of only one elective mastectomy using the simple mastectomy technique

that has had a subsequent development of carcinoma and that was in the tail of Spence.

Dr. John M. Beal: This is not a common problem but, with the frequency of breast cancer, may be encountered more often. Since breast carcinoma occurs in one of every six adult women, the problem of breast cancer prevention is real. As Dr. Kies mentioned, there is a significant increase in the risk of the development of carcinoma of the breast in women whose mothers had breast cancer before the age of 50 years. In some families, nearly every woman has developed breast cancer. This was the basic concern in the patient presented here. When we chose mastectomy to remove the potential of breast cancer in this woman, the mastectomy was performed to remove all breast tissue and would preferably be referred to as total mastectomy. In my opinion, it is more satisfactory, under these circumstances, to have one surgical team remove the breast and a second team reconstruct the breast. This permits each team to concentrate on their objectives and accomplish the operation in an optimum manner. ◀

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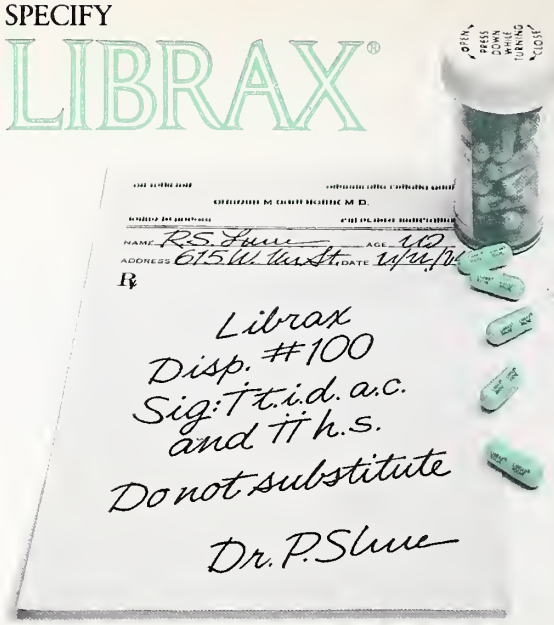


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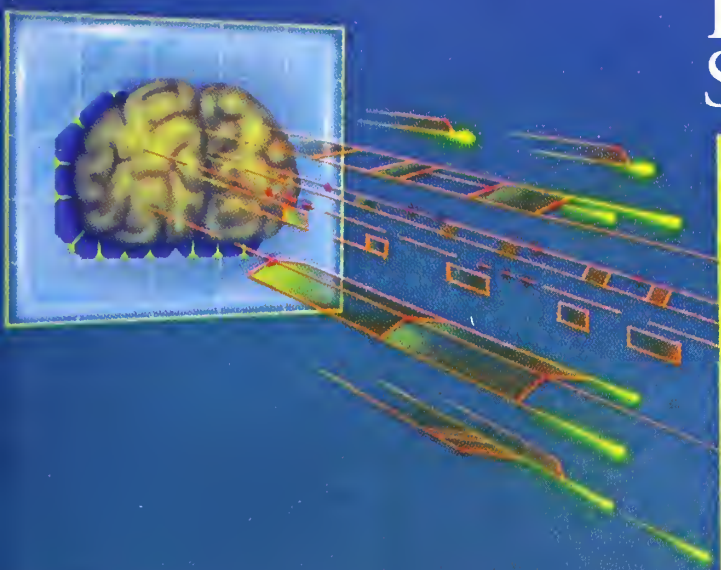
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Improved Reconstructed CT Images Of the Spine

By Glen D. Dobben, M.D./Chicago

Recent improvements in production of reconstructed CT images of the spine have changed the examination from a single plane to a multiplanar study. The single plane CT axial study of interspaces has valuable diagnostic information. However, the spine is oriented along a central longitudinal axis within the body and past familiarity of myelography is along this axis. The improved reconstructed images are in the lateral and frontal longitudinal axis, lending familiarity to the images needed to diagnose spinal problems. The reconstructed views require no added patient radiation.

Physicians have increasingly sought to reduce the number of myelographic procedures used to assess spine pain problems. Original CT studies of the spine included only sections through the interspaces. We have more recently realized that stenosis, osteophytic ridge formation, facet joint disease, and neuroforaminal pathology were not being properly assessed by limiting the spine study to the interspaces.[1-3] Because of this limitation reconstructed images in multiple planes have been added to the spine study.

Rapid changes and improvements in the software programming for reconstructed images have been cited here, also. Recently, software program advances have permitted improvements of image quality and changes from single image to multiplanar imaging. These images require no added radiation and may be programmed for an additional 20 views in the lateral, frontal and oblique projections.

In the past, all studies included only a few reconstructed lateral views of the spine. This was time consuming and expensive for the few pictures produced. The present method utilizes a time shared computer which permits improved images, but also yields an appreciable cost savings for the patient.[4] The format of display is easily understood by referring physicians.

The technique for computed tomography of the lumbar spine consists of multiple contiguous axial sections to cover the area. The slice thickness is 0.5cm with overlapping sections, to include either the whole lumbar spine, L3-S1 or L4-S1. The most frequent standard study is L3-S1. Single separate sections are obtained of L1-2 and L2-3 interspaces. The technique is not limited to the lumbar spine but is also indicated for the cervical and thoracic spine.

Transaxial CT scans contain valuable diagnostic information.[5-9] However, in structures within the body which are organized along a central long axis, more coherent information is presented in slices which cut the structures lengthwise. The spine is such a structure.

Lateral and frontal views are necessary to avoid misdiagnosis of disc disease produced by the section orientation in the axial projection. The advantage of familiarity with the lateral and frontal

Glen D. Dobben, M.D., is a board certified radiologist affiliated with the University of Illinois and C.T. Spine Center in Chicago. Dr. Dobben is a professor of radiology and neurosurgery and former head of the University of Illinois Department of Neuroradiology. A specialist in computer tomographic scanning of the brain and spine, he is also former director of the division of radiology, Cook County Hospital, Chicago.



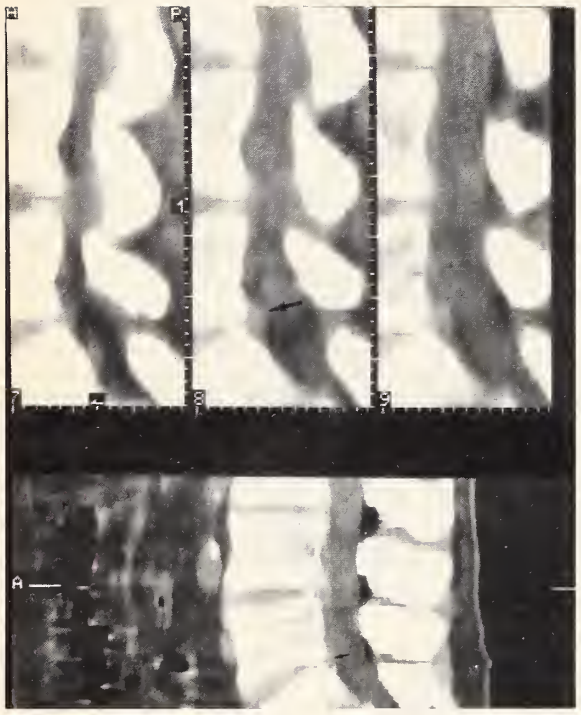


Figure 1
Non contrast reformatted lateral views of lumbar 3 to sacral 1 study. The three upper sagittal sections are 3mm. apart, and the L5-S1 disc is best seen in the middle section as marked with a large arrow. The lower sagittal section is at the same site, but utilizing the standard reformatted program. The disc is marked with a small arrow. Other than the life size of the upper sections, all other measurements are identical.

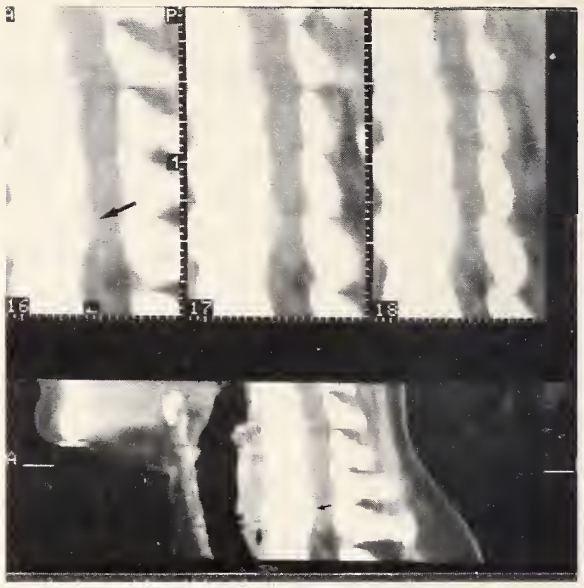


Figure 2
Non contrast CT reformatted lateral views of the third cervical vertebra to the first thoracic vertebra. The three upper sagittal sections are 2mm. apart. The large arrow marks the C6-7 disc. The lower reformatted section utilizes the standard reformatted program of the cervical spine. The small arrow marks the C6-7 disc. Other than the life size of the upper sections, all other measurements are identical.

views of myelography further ease understanding of the CT reconstructed tomograms.

Case Reports

The following are examples of these new and improved reconstructed images, compared to former single images. The same equipment was used in each case and all imaging parameters are identical for filming purposes.

Case 1: A 56-year-old male presented with a history of low back pain. Symptoms included pain radiating from the area of the right hip and along the lateral aspect of the right leg. Parasthesias of the entire right foot were very distressing to the patient. The neurological examination was considered normal.

The non contrast CT reformatted examination of the L3-S1 study of the lumbar spine demonstrates a soft tissue disc of L5-S1. (Figure 1.) The three upper sagittal sections are 3mm apart and the disc is best seen in the middle section, as marked with a large arrow. The lower sagittal section is at the same site, but utilizing the standard reformatting program, the disc is marked with a small arrow. Other than the lifesize of the multiplanar sections, all other measurement parameters are identical.

Case 2: A 50-year-old female reported decreasing sensations of the right hand for the previous several months. She had no pain in the arm or hand, but complained of back pain between the shoulders. Previous CT scan and myelogram of the cervical area were considered equivocal and nondiagnostic. The non-contrast CT reformatted examination of the C3-T1 study (Figure 2.) demonstrates a soft tissue disc at C6-7 with associated central stenosis. The three upper sagittal sections are 2mm apart. The large arrow marks the C6-7 disc. The lower reformatted section utilizes the standard reformatted program of the cervical spine. The small arrow marks the C6-7 disc. The only difference between the two studies, for comparison purposes, is the lifesize of the multiplanar images.

Conclusion

The newer, reformatted multiplanar CT images of the axial spine permit improved diagnostic expertise as pertains to spinal problems. This information is available without additional radiation exposure to the patient. The CT spinal study

should no longer be limited to the single interspace study.

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DANVILLE: Family Physicians desiring independent practice near a larger community with two hospitals and wanting the security of start-up support with guarantees. Call N. L. Saxton, M.D. (217) 443-5204 or send curriculum vitae to 812 North Logan Avenue, Danville, 61832. (4)

DYER, IN: Two board certified/eligible psychiatrists to establish practice in our service area: (1) Private practice with contractual arrangement in substance abuse program and (2) adult private practice with minimal guarantee until practice is established. Contact: Professional Recruiter, Our Lady of Mercy Hospital, U.S. Hwy. 30, Dyer, Indiana 46311 (219) 865-2141. (8)

GIBSON CITY: Cardiologist, Internist wanted to join expanding multi-specialty medical staff associated with modern well equipped hospital; ICU capable of invasive monitoring; attached privately funded SNF; new professional office space available; rural community in east central Illinois within 30 minutes of major universities, tertiary care centers, metropolitan areas with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City, 60936 (217/784-4251). (7)

GLEN ELLYN: Physicians wanted to staff urgent care and industrial medicine facility in private practice in western suburbs of Chicago. Hourly base plus incentive package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, S. C., 454 Pennsylvania Ave., Glen Ellyn 60137. 312-469-9200. (5)

GLEN ELLYN: Physicians wanted—internist and family physician to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. CONTACT: Dave Bauer, Adm., Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave., Glen Ellyn 60137 (312-469-9200). (5)

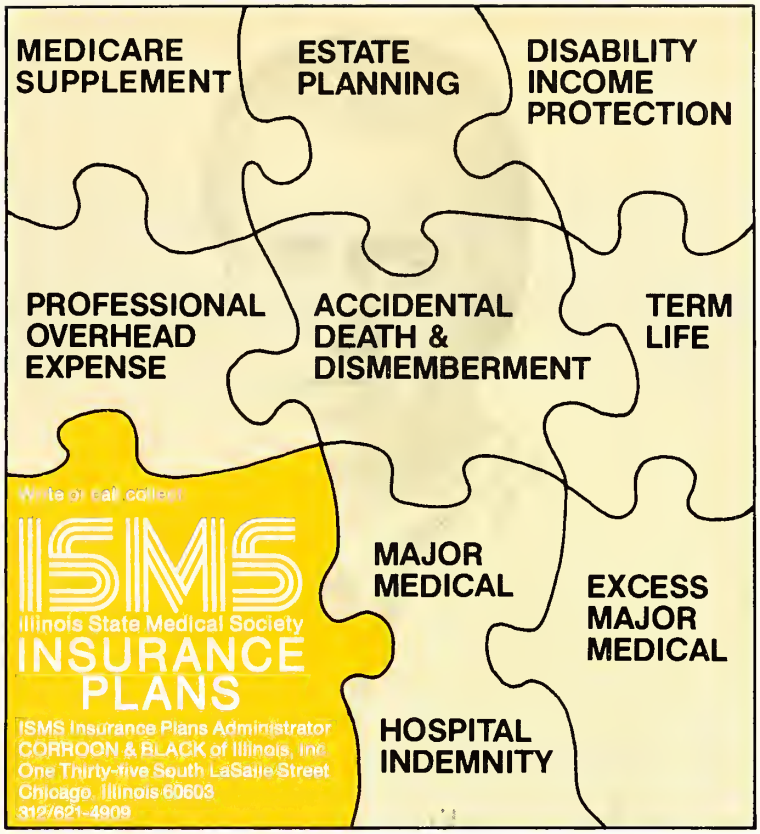
SAYBROOK: Family practitioner—Excellent opportunity in East Central Illinois; large modern office available due to recent physician retirement; rural setting near modern well equipped community hospital; also within twenty minutes of major university tertiary care center, metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact: William Stack, Saybrook 61770. (309) 475-3521. (5)

SOLVE YOUR PROTECTION PUZZLE

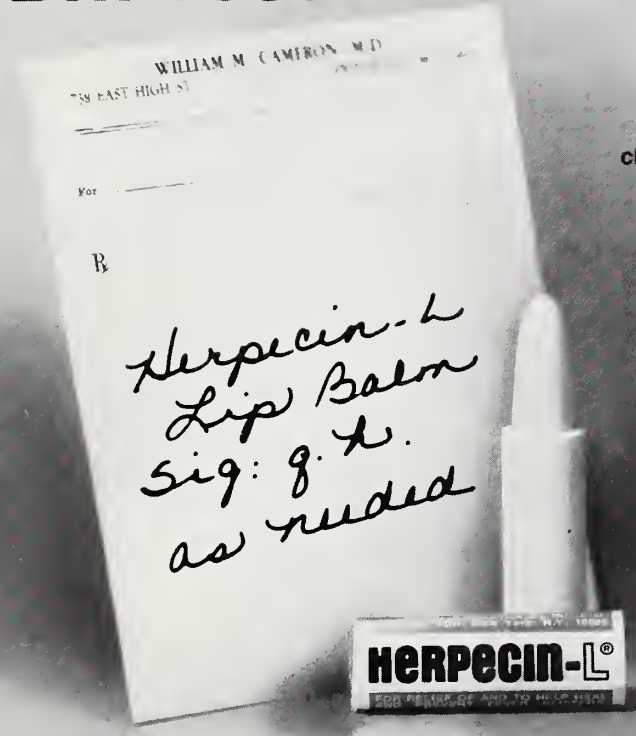
The insurance puzzle... are there pieces missing from your picture?

As a member of ISMS, you can realize substantial benefits by participating in society-approved insurance plans. Designed and administered by professionals in cooperation with ISMS, this program could be the answer to your personal and professional needs. While your requirements receive individual attention, you also enjoy the economies of ISMS group purchasing power.

COMPLETE PROGRAM PROFILE OFFERED WITHOUT OBLIGATION



Dx: recurrent herpes labialis



"Herpecin-L Lip Balm is **the treatment of choice** for peri-oral *herpes.*" GP, New York

"In the management of *herpes labialis,* Herpecin-L is a **conservative approach** with **low risk-high benefit.**" Derm., Miami

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In Illinois, "HERPECIN-L" Cold Sore Lip Balm is available at all *Medicare, Glaser, Osco* and *SupeRx Drug Stores* and other select pharmacies.

Illinois Society, American Association of Medical Assistants

Help For The Busy Physician

It should be obvious that the more knowledge and training an assistant has, the more help she can be to you in running a more productive and efficient office. Yet many physicians employ someone with no prior training or special qualifications for the job.

We are not recommending that all such assistants be discharged, but rather that all such employees can be greatly aided by one simple and pleasant step—membership in Illinois Society, American Association of Medical Assistants.

Membership in this organization confers many immediate and practical benefits, both to the medical assistant and to the employer.

- Continued education and professional stimulation. Proven methods of efficient operation and office management techniques are provided by annual national and state meetings, seminars and educational symposia. Advice may be obtained regarding individual problems through personal attention from the office of the American Association of Medical Assistants. This saves the busy physician much time and energy he might expend in such training.
- Affiliation with others and interchange of ideas on how to be a better medical assistant.
- The Illini Cardinal, a professional journal which prints articles of interest to medical assistants and news of Illinois Society activities.
- Comprehensive group insurance program-providing most types of insurance including professional liability coverage for members.
- Increased status and prestige for the medical assistant.
- New friendship and fellowship with others in various communities with Illinois Society Chapters.

No one has more to gain through membership in Illinois Society than the medical assistant, with the possible exception of you, her employer. Although your assistant may be just what you ordered, perhaps a little extra finesse can turn her into an unbelievable find! ! ! Imagine what this can do to improve her efficiency and your public relations.

It behooves every physician to urge his medical assistant to join an organization dedicated to better service to his or her profession and the public.

Information regarding Illinois Society, AAMA, may be obtained from Betty Kronemeyer, CMA, president, 809 N. 10th, Mascoutah IL 62258 or Lisa Greene, CMA-C, chairman, public relations committee, 8836 W. Grand, River Grove, IL 60171. ◀

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Illinois State Medical Society
Political Action Committee
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

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Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations. Sections 110.1, 110.2, & 110.5 (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

Doctor's News

PHYSICIANS IN THE NEWS—**Bertram B. Moss, M.D.,** Chicago, has been appointed chairman of the Long Term Care Advisory Board of the City of Chicago Department of Health.

Michael H. M. Dykes, M.D., Chicago, has been appointed to the Board of Governors of the American College of Anesthesiologists for a three year term.

Recently elected ISMIE officers are: **Fred Z. White, M.D.,** Chillicothe, chairman; **Walter A. Whisler, M.D.,** Wilmette vice-chairman; and **Irwin A. Smith, M.D.,** Northbrook, secretary.

John C. Cacioppo, M.D., Oak Brook, has been elected to the board of trustees of Columbus-Cuneo-Cabrini Medical Center, Chicago.

Leonard Berlin, M.D., Wilmette, was recently elected chairman of the board of trustees of Skokie Valley Hospital and chairman of the board of directors of Skokie Valley Health Services, the hospital's new parent corporation.

Newly elected officers of the Illinois Dermatological Society are: **Allan L. Lorincz, M.D.,** Oak Lawn, president; **Robert G. Carney, Jr., M.D.,** Decatur, president-elect and secretary-treasurer; **Milton Robin, M.D.,** Chicago, ISMS Council on Affiliate Societies representative; and **Robert M. Goodwin, M.D.,** Springfield, ISMS House of Delegates representative.

NATIONAL CONFERENCE ON EATING DISORDERS—The National Association of Anorexia Nervosa and Associated Disorders (ANAD) and the Highland Park Hospital are cosponsoring a national conference on eating disorders June 11-12 at the Westin Hotel in Chicago.

The two-day conference will consist of workshops covering treatment of life threatening disorders and support groups. Internationally known experts in the field, Paul E. Garfinkel, M.D. and David M. Garner, Ph.D. will be among the speakers.

For further information contact the Anorexia and Bulimia Conference, ANAD, Box 271, Highland Park, IL 60035; (312) 831-3438.

AMA ANNUAL MEETING—The American Medical Association's House of Delegates annual meeting will be held June 19-23 at the Chicago Marriott Hotel. The House will convene at 2 p.m. Sunday, June 19. Further information may be obtained through Jane Coughlin (312) 751-5109 or Thomas Toftey (312) 751-6594.

PREMIUM CREDIT ON WORKERS' COMPENSATION OFFERED—Physicians joining the dividend plan for workers' compensation insurance now will receive an advanced premium credit of 15%. The offer from the Dodson Insurance Group, which manages the dividend plan, applies to all new and renewal policies at the time they are issued.

The dividend plan approved by ISMS in 1978 remains in effect. Dividends have averaged 25.4% during the past four years for insured doctors and are paid by individual checks after the policy expires each year. For more details, physicians may call Dodson toll-free at 800-821-3760.

NEW ISMS MEDICARE SUPPLEMENT PROGRAM—ISMS members aged 65 and over may participate in a new ISMS Medicare supplement program designed to fill the gaps created by Medicare deductibles and co-insurance requirements as well as other medical and surgical services not covered by Medicare.

The supplement program now covers members and their spouses. The new program was established in response to the interest generated from ISMS members currently insured by other Medicare supplement programs.

The plan is underwritten by the Hartford Accident and Indemnity Company. ISMS has mailed brochures regarding the new program to physicians. For more information, physicians may call the ISMS insurance department.

SEMINAR FOR FOREIGN PHYSICIANS—Due to the success of the seminars last year, AMA is again sponsoring an English pronunciation seminar for foreign physicians on May 22. The intensive one day seminar will be held from 9 a.m. to 5 p.m. at the Inn of Chicago, 162 E. Ohio St., Chicago.

The program, designed to help foreign medical graduates improve communication with patients and colleagues, will include lectures and oral drilling on American English sounds.

Teaching the seminar will be a husband and wife team from Cleveland, Ohio, Robert Lang, Ph.D., director of the Cleveland Academy of Medicine and Elizabeth K. Lang, M.A., associate professor of speech communications at Cuyahoga Community College and author of the book titled "Improving English Pronunciation."

Participants are asked to bring a small tape recorder with an extension cord and two or three blank cassettes. Nine audio tapes and a 134 page study guide containing 47 lessons on sounds of American English and problems of accents will be provided at the seminar.

Tuition fees for the seminar are as follows: $156 for AMA members; $108 for AMA resident members; $204 for nonmembers; and $132 for nonmember residents. The fee includes the cost for the text and audio tapes, breakfast and lunch.

For further information contact Mr. Gale K. Jewett, Department of Medical Information and Physician Qualifications, American Medical Association, 535 N. Dearborn St., Chicago IL 60610, or call (312) 751-6570.

NUCLEAR MEDICINE SPEAKERS BUREAU—The American College of Nuclear Physicians (ACNP) Speakers Bureau consists of scientists and physicians practicing nuclear medicine. Due to misconceptions about nuclear medicine and nuclear waste, the ACNP is providing the bureau speakers as a service, free of charge, to educate the public on the practice of nuclear medicine, the use of radioactive materials and low-level waste disposal.

The ACNP speakers can explain the risks and benefits of nuclear medicine; describe the low-level waste issues on the national and state level; explain how to effect low-level nuclear waste decisions by governmental bodies; and discuss the multiple sources of radiation exposure in our daily lives. Speakers can explain how nuclear medicine can diagnose some diseases before symptoms appear and can detect cancer, clots in the lung, early pregnancy, injury of the heart and drug overdose.

Persons interested in sponsoring an ACNP speaker should contact Barbara Teele, collect, (202) 857-1191 or write to the American College of Nuclear Physicians, Suite 700, 1101 Connecticut Ave., N.W., Washington, D.C. 20036.

PAPERS SOUGHT FOR ANNUAL PRIZES—The Institute of Medicine of Chicago is offering two annual prizes for research papers in the fields of orthopaedic surgery and arthritis.

Author of the best thesis for original research work in the field of orthopaedic surgery completed in 1983 will be awarded the Dr. and Mrs. Elven J. Berkheiser prize of $750. The investigation may be in fundamental sciences provided the work has a definite bearing on orthopaedic conditions.

The John L. and Beatrice S. Keeshin prize of $1000 will be awarded for the best thesis for original research work in the field of Gaucher's Disease or arthritis completed in 1983.

The greater part of the works must have been completed in a metropolitan Chicago institution. The papers may not have been published prior to submission. Physicians who received their M.D. degree within six years of July 2, 1983 (excluding terms of active duty in the Armed Forces) must submit their manuscripts in quadruplicate and a resume (including S.S. number) to the Secretary of the Institute of Medicine of Chicago by November 15, 1983.

The prize winning papers will be published in the *Proceedings of the Institute of Medicine of Chicago.* For more information or to submit papers contact the Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, IL 60604.

ISMS ELECTION RESULTS—ISMS elections were held during the recent 1983 ISMS House of Delegates annual meeting. Listed here is the newly-selected leadership. *IMJ* will carry more complete coverage about the elections and other House business in its next issue.

Inducted as president was Dr. Robert P. Johnson, of Springfield. Chosen as president-elect was Dr. Robert C. Hamilton, of Chicago. Other newly-named officers were Dr. Ronald G. Welch, Belleville, first vice-president and Dr. Alfred J. Clementi, Arlington Heights, second vice-president. Dr. Jere E. Freidheim, Chicago, retained his seat as secretary-treasurer. Dr. Julian W. Buser, Belleville, was named speaker of the house and Dr. Lawrence L. Hirsch, Chicago, was selected vice-speaker.

Newly-chosen for third district trustee spots were Dr. James E. Andersen, Oak Brook, Dr. Harold L. Jensen, Flossmoor, Dr. Pedro A. Poma, Melrose Park, and Dr. Harry A. Springer, Winnetka. Dr. Clifton L. Reeder, Wilmette and Dr. Arthur R. Peterson,, Chicago, were chosen to fill third district seats vacated by election of trustees to other offices. Elected to the eleventh district trustee position was Dr. Raymond A. Dieter, Glen Ellyn. Elected twelfth district trustee was Dr. Raymond E. Hoffmann, Rockford. Two trustees whose terms were expiring were re-elected: Dr. Allan L. Goslin, Streator, second district, and Dr. Audley F. Connor Jr., Chicago, third district.

Dr. Warren D. Tuttle, Harrisburg, was re-elected as chairman of the board of trustees.

Retaining their positions as AMA delegates were: Dr. Howard C. Burkhead, Evanston, Dr. Morgan M. Meyer, Lombard, Dr. Joseph H. Skom, Chicago, and Dr. Cyril C. Wiggishoff, Chicago. Elected as AMA delegates were: Dr. Robert P. Johnson, Springfield, Dr. Alfred J. Clementi, Arlington Heights, Dr. Robert C. Hamilton, Chicago, and Dr. Arthur R. Traugott, Urbana. Elected as the 17th delegate to the AMA was Dr. Michael L. Nieder, Chicago.

Retaining their spots as AMA alternate delegates were: Dr. Allan L. Goslin, Streator, Dr. A. Beaumont Johnson, Elgin, Dr. Ronald G. Welch, Belleville, and Dr. Fred Z. White, Chillicothe. Elected as AMA alternate delegates were: Dr. Warren D. Tuttle, Harrisburg, Dr. Randall T. Bellows, Chicago, Dr. Jere E. Freidheim, Chicago, Dr. Harold L. Jensen, Flossmoor, Dr. James De Bord, Peoria, and Dr. Pedro A. Poma, Melrose Park. Richard Terek, a student, was named to fill the position vacated by Dr. Neider and also to serve a full term as an alternate delegate from January 1984 to December 1985.

HEALTH CARE COST CONTAINMENT EFFORTS—The American College of Emergency Physicians Cost Containment Project has targeted 35 high-cost, high-frequency diagnostic tests for cost reduction. These tests were selected after 22 hospitals participating in the project collected data on 100 highest-total-cost tests ordered in the emergency departments.

Some of the tests targeted for reduction are chest X-rays, CBC, skull X-rays, extremity X-rays and throat cultures. Educational sessions will be held for three months by each participating hospital. ACEP will develop educational materials and help each hospital analyze data collected before and after the program.

NEW MEDICAL STUDENT FUND—The AMA Education and Research Foundation has created a new fund to assist medical students. The "Medical Student Assistance Fund" will add resources to the student financial aid programs and medical school student loan programs, according to a recent AMA Newsletter.

Schools designated by a donor will receive the AMA-ERF gift in its entirety. Collected funds will be distributed once a year. Each medical school will receive a monthly list of the donors and their designated gifts.

Since the Foundation's unrestricted medical school fund program will continue as it has since the early 1950's, schools will receive two checks from separate funds beginning in 1984. The state medical societies will present the check at the same time the ERF's unrestricted medical school fund check is presented. ◀

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(217) 544-2251

EKG

(Continued from page 321)

Answers: 1. E 2. D

The twelve lead ECG shows sinus rhythm with upright P waves in all leads except lead AVR. The PR interval is short, less than, or equal to 0.11 seconds in all leads. The QRS is prolonged to 0.14 seconds at its widest in the precordial leads. The prolonged QRS is caused by a large delta wave. The delta wave is the slurred upstroke of the QRS. It goes to the tip of the R wave in lead I and part way up in leads II, V_4, V_5 and V_6. The typical ECG of the WPW syndrome has a short PR interval and a delta wave. The QRS is the result of fusion of impulses coming down the AV node-bundle of the HIS pathway and the accessory pathway (bundle of Kent). The accessory pathway allows a portion of the ventricles to be prematurely activated by the sinus impulse. The widened QRS is frequently confused with complete left bundle branch block. The QRS is often high voltage and can resemble severe left ventricular hypertrophy. The ST-T wave changes are secondary to the ventricular activation and can look like ischemia in some cases. However, the shortened PR interval is the first clue and this should prompt a search for the delta wave.

None of the answers in question 2 are correct. The ECG of WPW syndrome was incidental in this patient but it could have caused confusion. Kidney transplant rejection was considered and ruled out. Urine culture subsequently grew out *E coli*. Appropriate antibiotic treatment returned the patient to her previous state of health. ◀

Brief Summary of Prescribing Information

INOICATIONS — For management of anxiety disorders or short-term relief of symptoms of anxiety: for symptomatic relief of acute alcohol withdrawal: for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

AOVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

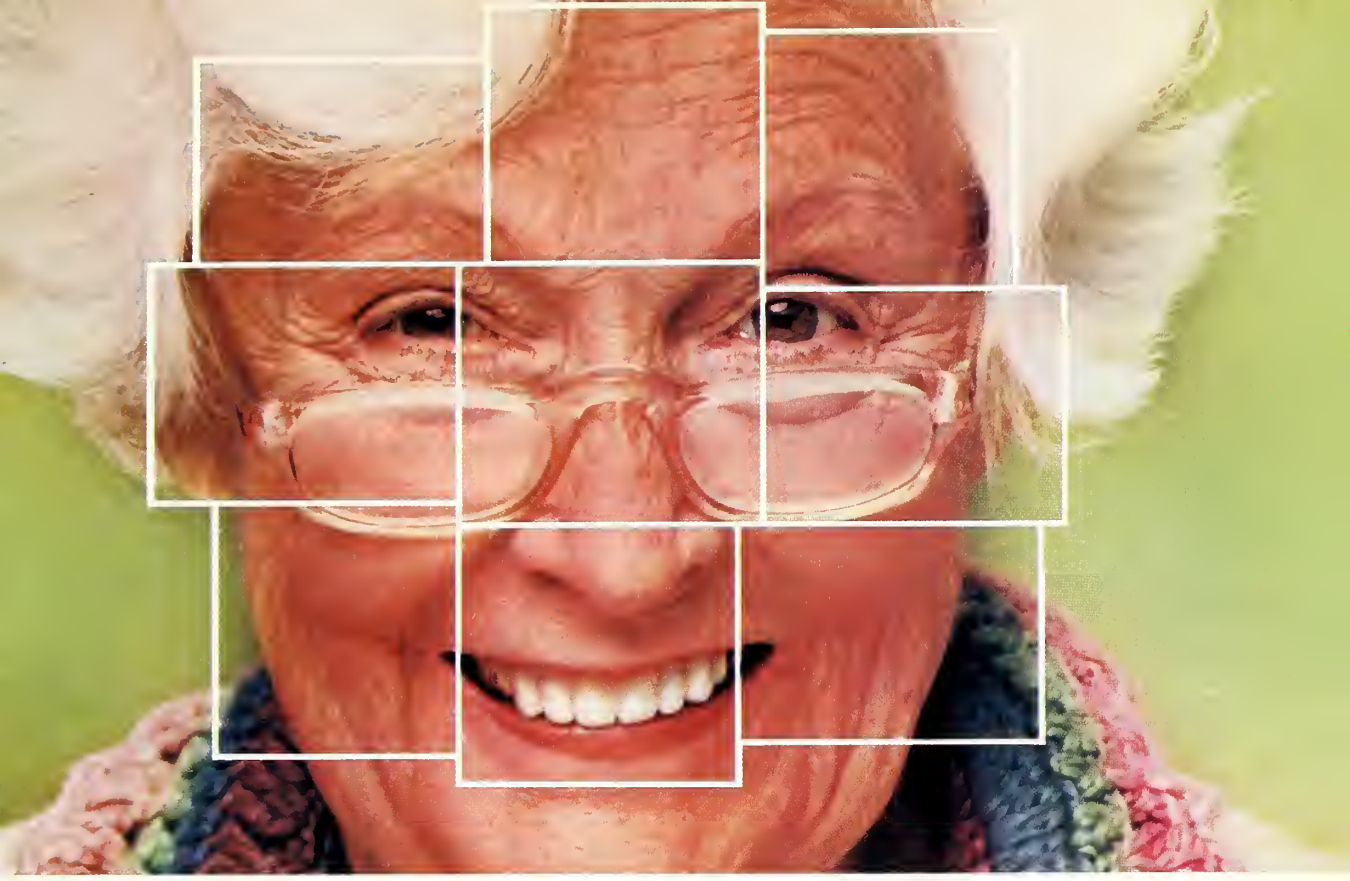
OVEROOSAGE — Take general measures as for any CNS depressant.

SUPPLIEO — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

Tranxene®
clorazepate dipotassium Ⓒ
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During anxiety therapy...

Tranxene calms with a low incidence of problem sedation* and without likelihood of amnesia

In direct comparisons Tranxene has been shown equal to or lower than diazepam[1-9] in incidence of problem sedation.* And although Tranxene studies were not specifically designed to investigate anterograde amnesia, there have been no reports of this problem in the literature in over a decade of clinical use. The Tranxene record is impressive.

*Problem sedation is defined as moderate to severe degrees of sedation, sleepiness; drowsiness, lassitude.

Tranxene®

clorazepate dipotassium Ⓒ IV

Calms with care

3.75, 7.5, 15 mg capsules, scored tablets; 11.25, 22.5 mg single-dose tablets.
For brief summary, see an adjacent column.

ABBOTT 3053551

1. Barker MA, Davenport RH et al: *Practitioner* 215:98-101, 1975 2. Cooper AJ, Magnus RV et al *Br J Psychiatry* 123 475-476, 1973 3. Feurst SI *Curr Ther Res* 15:449-459, 1973 4. Magnus RV: *Br J Clin Pract* 27 449-452, 1973. 5. Magnus RV, Dean BC et al *Dis Nerv Syst* 38 819-821, 1977 6. Mielke DH, Gallant DM et al: *Curr Ther Res* 19 506-511, 1976 7. Ricca JJ *J Clin Pharmacol* 12:286-290, 1972. 8. Robin A, Curry SH et al *Psychol Med* 4 388-392, 1974 9. Wiersum J: *Curr Ther Res* 14 442-448, 1972.

Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JUNE

Cardiology

Cardiac Rehabilitation
For: GP's, FP's, Internists. Seminar, June 10-11, Hyatt Regency, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr., E., Englewaad, CO 80112. **Reg. deadline:** none. **Fee:** $260. **Reg. limit:** B5. **Credit:** Categary 1, 13 hours; AAFP Prescribed, 13 haurs; AOA, 13 hours. **Contact:** Doris Price. **Phone:** B00/525-B651 x 123.

Critical Care

Review in Critical Care Medicine
For: MD's. Course, June 13-17, Hyatt Regency, Chicago. **Sponsor:** American Callege af Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** $350, member; $400, nan-member. **Reg. limit:** none. **Credit:** Category 1, 37 hours. **Contact:** Dale Braddy. **Phone:** 312-696-2200.

Family Medicine

Clinical Medicine Update
For: GP's, FP's. Lecture, June 13-17, Chicago. **Speaker:** Sheldan Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $350. **Reg. limit:** 90. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Geriatrics

Geriatric Problems
For: MD's. Symposium, June 2, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 6270B. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/7B2-7711.

Headache

Annual Meeting
For: MD's, DO's, DDS's. Lectures, June 24-26, Four Seasons Hatel, Toronto, Canada. **Sponsor:** American Associatian for the Study of Headache, 5252 N. Western Ave., Chicago 60625. **Reg. deadline:** 6/1. **Fee:** $100, non-members. **Reg. limit:** none. **Credit:** Category 1, 18 hours; AAFP Prescribed, 18 hours; AOA, 2-D. **Contact:** Seymour Diamond, MD. **Phone:** 312/878-555B.

Internal Medicine

Internal Medicine Symposium
For: MD's. Symposium, June 17-1B, Springfield. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/7B2-7711.

OB/GYN

Open Laparoscopy Workshop
For: Ob/Gyn, Surgeons, FP's. Workshap, June 4, B:00 a.m., Chicaga. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Reg. deadline:** 5/15. **Fee:** $150; residents, $75. **Reg. limit:** 100. **Credit:** ACOG, 7 hours. **Contact:** Harrith Hasson, MD. **Phone:** 312-BB3-5638.

OB-GYN

Ob-Gyn Review Course
For: MD's. Course, June 6-11, Americano Congress Hotel, Chicago. **Sponsors:** 7 medical schools in Illinois. **Fee:** $450; $350, residents. **Reg. limit:** nane. **Credit:** Category 1, 34 hours; ACOG cognates, 34. **Contact:** CME, University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. **Phone:** 312/962-1056.

Oncology

Head and Neck Cancer
For: GP's, FP's, DDS's, Oral Surgeons. Symposium, June 16, Urbana. **Sponsor:** CME, Carle Foundation Hospital, 611 West Park St., Urbana 61801. **Cosponsor:** U af I College of Medicine. **Reg. deadline:** none. **Fee:** $35. **Reg. limit:** none. **Credit:** Category 1, 3½ hours; AAFP Elective, 3½ hours. **Contact:** Deborah Rugg. **Phone:** 217-337-3022.

Pathology

Liver & GI Clinico-Pathologic Conference
For: MD's. Lecture, June 28, 4:30 p.m., North Chicago. **Sponsor:** Dept. af Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicaga 60064. **Fee:** none. **Credit:** Categary 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Pathology

Laboratory Evaluation of Cerebrospinal Fluid
For: Pathologists. Lecture, June 13, 7:30 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, M.D., Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Cosponsor:** Michael Reese Hospital. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312/626-4300 x 3B3.

Pediatrics

Specialty Review in Pediatric Cardiology
For: Pediatric Cardiologists. Lecture, June B-11, Chicago. **Speaker:** Mario Serratta, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $325. **Reg. limit:** 90. **Credit:** Category 1, 28 hours. **Contact:** Robert Baker, M.D.

Pharmacology

What's New in Psychiatric Drugs and Anti-Inflammatory Agents
For: primary care physicians. Symposium, June 10, Madison, WI. **Sponsor:** University of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** TBA. **Reg. limit:** nane. **Credit:** Categary 1; AAFP Elective; AOA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Pulmonary Disease

Pulmonary Medicine Update
For: MD's. Conference, June 17-18, Madisan, WI. **Sponsor:** University of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category TBD. **Contact:** Sarah Aslakson. **Phone:** 608/263-2B56.

JULY

Emergency Medicine

Old Dilemmas in the Emergency Room
For: Emergency Physicians. Lectures/workshops, July 21-22, Madisan, WI. **Sponsor:** U af WI—Extension, CME, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $175. **Reg. limit:** none. **Credit:** Category 1, 13 hours; AOA, 13 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2B56.

Emergency Medicine

Managing the Unmanageable
For: MD's. Conference, July 23-24, Madisan, WI. **Sponsor:** U of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madisan, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 10 hours; AAFP Elective, 10 hours; AOA, 10 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Dermatology

Practical Office Dermatology
For: Internists, Pediatricians, FP's, GP's. Lecture, July 12-16, Chicago. **Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $350. **Reg. limit:** 85 hours. **Credit:** Category 1, 37 hours. **Contact:** Rabert Baker, MD. **Phone:** 312-733-2B00.

Gynecology

Office Gynecology
For: Internists, FP's, GP's. Lecture, July 12-14, Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School af Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $250. **Reg. limit:** 85. **Credit:** Category 1, 21 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2B00.

Medicine

Environmental Medicine
For: Internists, FP's, GP's, Occupotional Medicine. Lecture, July 19-23, Chicago. **Speakers:** Stephen Greenberg, PhD; Emersan Doy, MD. **Sponsor:** Cook Caunty Graduate School of Medicine, 707 S. Wood St., Chicaga 60612. **Fee:** $325. **Reg. limit:** 85. **Credit:** Category 1, 30 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Medicine

Specialty Review in Internal Medicine/Certifying
For: Internists. Lecture, July 25-Aug. 1, Chicaga. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School af Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 600. **Credit:** Cotegory 1, 72 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Pothology

Liver & GI Clinico-Pathologic Conference
For: Pathologists. Lecture, July 26, 4:30 p.m., North Chicaga. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** none. **Credit:** Cotegory 1, 2 hours. **Contact:** Ben Blivoiss, PhD. **Phone:** 312-578-3215.

Pediatrics

Specialty Review in Pediatrics
For: Pediatricians. Lecture, July 19-24, Chicago. **Speaker:** Ira DuBrow, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Reg. limit:** 300. **Credit:** Cotegory 1, 63 hours. **Contact:** Robert Boker, MD. **Phone:** 312-733-2800.

Urology

Summer Clinical Series
For: Urologists. Course, July 30-31, Palmer House, Chicago. **Sponsor:** American Urologicol Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 7/30. **Fee:** yes. **Reg. limit:** 200. **Credit:** Categary 1. **Contact:** Alice Henderson. **Phone:** 713-790-6070.

AUGUST

Sports Medicine

6th Annual Sports Medicine Symposium
For: MD's, RN's, coaches. Symposium/workshops, August 5-6, Wounokee, WI. **Sponsor:** University of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Modison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 13 hours; AOA, 13 hours; AAFP Elective, 13 hours. **Contact:** Saroh Asloksan. **Phone:** 608-263-2856.

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Viewbox

(Continued from page 328)

Diagnosis: (1) Genitourinary Tuberculosis

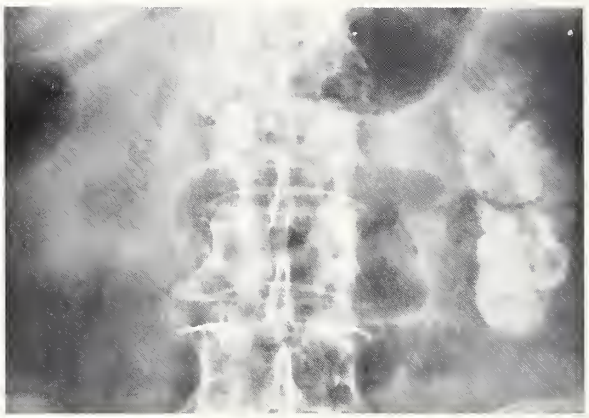


Figure 2
Plain radiograph with tuberculous autonephrectomy of left kidney. Calcification identifies what has been called a putty kidney.

The combination of infundibular stenosis and an abnormal renal papilla (Fig. 1) in a patient with chronic urinary tract symptoms and abnormal urinalysis should lead to strong suspicion of tuberculosis, especially with a past history of pulmonary infection.

Early changes of papillary necrosis can be identical to early tuberculosis and both may cause unilateral changes. Papillary necrosis, however, doesn't cause infundibular stenosis. Transitional cell carcinoma can cause infundibular stenosis but wouldn't cause changes of papillary necrosis.

Brucellosis closely resembles tuberculosis when the kidney is involved. Kidney involvement, however, is rare. A history of working with meat might lead to the diagnosis, which requires special culture techniques.

Radiation damage involves small vessels and results in a small kidney with a smooth outline and a normal collecting system. Up to half of these patients develop hypertension.



Figure 3
Tuberculosis of kidneys with extensive calcification on right and calculi on left.

Tuberculosis is still a major health problem. The number of new active cases in the United States declined from 84,000 in 1953 to 32,000 in 1972. The incidence of extrapulmonary tuberculosis, however, remained stable during this time period so that about 12% of all newly reported active tuberculosis was extrapulmonary.[1]

The incidence of genitourinary tuberculosis is unknown. It has been found by screening, however, that 2-5% of some groups of patients with pulmonary tuberculosis have genitourinary tuberculosis.[2,3] There are an estimated 250,000 patients with active pulmonary tuberculosis in the United States and it is estimated that as many as 12,500 have genitourinary tuberculosis.[4]

Many of these patients have silent or insidious disease. A diligent watch is needed to avoid missing genitourinary involvement in any patient with a history of tuberculosis, since there may be a delay of many years between a pulmonary infection and clinical genitourinary disease.[3]

Pathology

During the hematogenous phase of a primary tuberculosis infection there is widespread hematogenous spread of bacilli and both kidneys are seeded. Most foci in the kidneys heal without development of renal disease. There may be pro-

gression of renal infection when there are large numbers of organisms, exceptionally virulent organisms, or a local or general lack of host resistance. The initial foci are probably located in arterioles of the renal cortex or glomeruli. In either case, with progression there is necrosis and spread of organisms down tubules to the loop of Henle where caseation and cavitation then lead to ulceration of the calyceal wall and discharge of bacilli into the renal pelvis and ureters. The ulcerated cavities provide the first sign of renal tuberculosis on excretory urography which is similar to papillary necrosis.

The disease then can spread to the infundibuli, other calices, renal pelvis, ureters, and bladder. Initially there are granulomatous lesions, edema, round cell infiltrates and cavitation. Later, fibrosis develops. The most common areas for fibrotic stricture are areas of normal anatomic narrowing; infundibula, the ureteropelvic junction and the ureterovesical junction. Healing may be associated with fibrotic strictures despite therapy. This may be related to cellular immunity. Late calcification occurs.[3]

In men, the prostate, seminal vesicles, and epididymis may be involved by tuberculosis. A fistula from the epididymis to the scrotum may occur. Genital tuberculosis in women may produce pelvic inflammatory disease with large masses and fistulae to the ureters, bladder or intestine.[6]

Clinical

The majority of patients with genitourinary tuberculosis have nonspecific and mild urinary tract symptoms which has been emphasized by the large percentage of patients who have had advanced cavitary kidney disease or renal failure on initial diagnosis.[5] There have been reports of nontuberculous mycobacteria causing genitourinary infection, but these are rare.

Symptoms related to bladder inflammation are most common. Frequency and dysuria may have been present for months or years and occur in about half of these patients. Nocturia, pain, urgency, and gross hematuria are less common.[2,6] There may be renal colic with passage of blood clots.[7]

Pyuria is more common than hematuria[7] and occurs in a majority of patients. Fever is rare but an elevated sedimentation rate was found in 15/66 patients in one report.[2]

A normal chest radiograph certainly does not exclude genitourinary tuberculosis. A minority of patients have evidence of active tuberculosis on chest radiographs and 25-75% have normal chest

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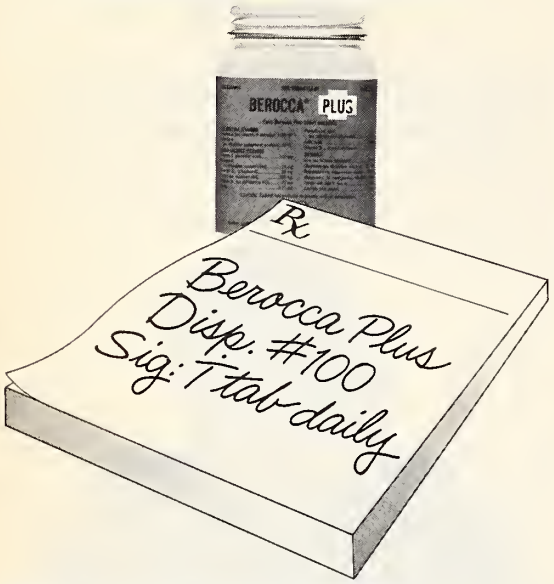
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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

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DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets — bottles of 100.

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Figure 4
Tuberculous amputation of infundibulum to upper pole calyx (large arrow). Small arrows outline the upper pole which is devoid of opacified calices.

radiographs.[2,6,7] In one series of 44 patients, 38/44 had positive intermediate strength tuberculin tests. Of the 6/44 with negative tests, two had miliary tuberculosis and two were elderly.[7] Cystoscopy often detects signs of cystitis and abnormality of the ureteral orifices which may be gaping, retracted, or stenosed.

In order to detect or identify organisms as M. tuberculosis, urine culture is needed. Culture of three first voided morning specimens have been found to equal the yield of 24 hour collections. Since discharge of bacilli is intermittent, frequent cultures are important in a patient suspected of having genitourinary tuberculosis.[3]

Plain Radiograph—Calcifications (Fig. 2, 3)[3,4,6,8]

Focal, indistinct calcifications occur in areas of caseation within the kidney. They may be faint



Figure 5
There are extensive tuberculous changes with deformity of all calices, replacement of the upper pole calix by a cavity (curved arrows) and amputation of a lower pole infundibulum (straight arrow).



Figure 6A

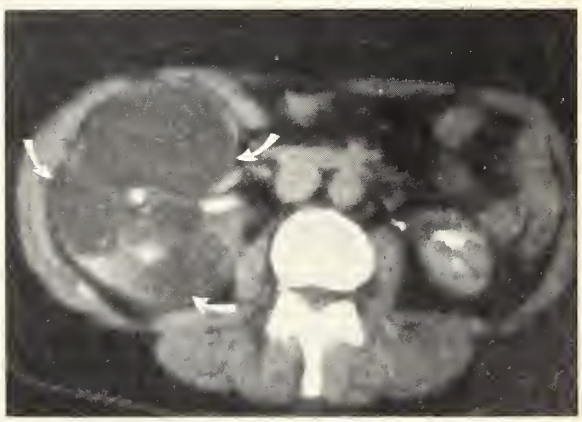


Figure 6B

Figure 6
(A) Long standing inactive renal tuberculosis with amputation of the upper pole infundibulum (arrow), cystic lesions of the upper pole and calcifications. Note abnormal spine due to tuberculosis (B). The right upper pole is replaced by fluid filled cystic lesions.

and focal. Characteristically, a destroyed kidney is densely calcified throughout (the putty kidney of autonephrectomy). The kidney is the most common site of calcification (Fig. 2, 3).

Ureteral calcification is unusual and may mimic a calcified ureteral calculus. Calcification with shistosomiasis is more frequent and involves the lower ureters (which are dilated) in addition to the bladder.[6] Tuberculous bladder calcification is relatively rare.

Prostatic calcification occurs but is identical to calcification found in dilated ducts following prostatitis. Calcification also occurs with tuberculous involvement of the vas deferens and seminal vesicles. Tuberculous calcifications are

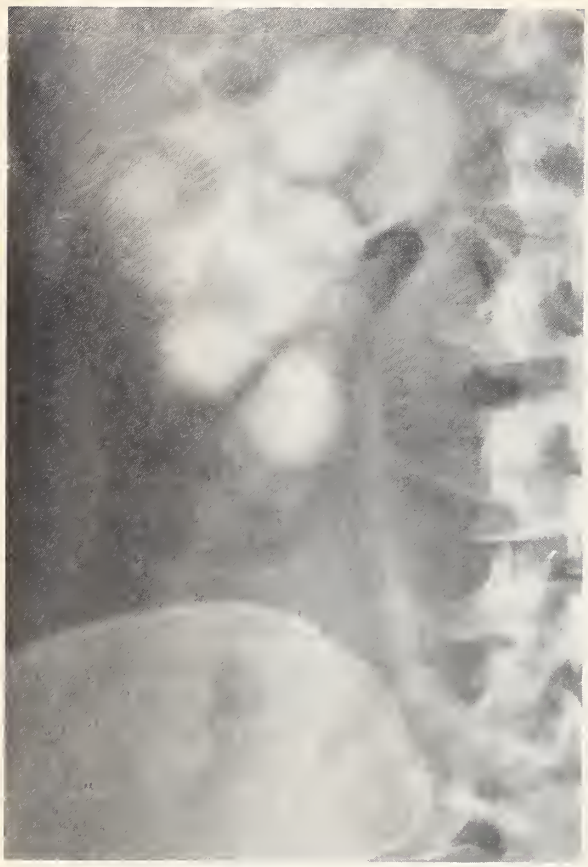


Figure 7A



Figure 7B

Figure 7
(A) Gross caliectasis on excretory urogram. (B) Narrowed ureter has a beaded appearance which is highly suggestive of tuberculosis but not specific. Ureteritis cystica, leukoplakia, malacoplakia, fungal disease, extensive uroepithelial malignancy, ureteral edema, and a congenitally unused ureter may result in a similar appearing ureter.

frequently found in the spleen and less often in mesenteric lymph nodes.

Calcifications in these later sites due to tuberculosis are usually indistinguishable from those due to histoplasmosis. Elongated calcifications along the psoas muscles, however, are characteristic of tuberculous psoas abscesses.

Excretory Urogram—Kidney (Fig. 1, 4-7)

The initial signs of tuberculosis are often subtle and focal. Small linear, rounded, or irregular collections of contrast material in the renal papillae are identical to papillary necrosis from other causes (Fig. 1). With progression, there is more caliceal irregularity and the calices may have a poorly defined, irregular, "moth-eaten" appearance. Infundibular stenosis or cutoff is common (Fig. 1, 4-6). Large caseous cavities may fill and eventually an entire group of calices may be destroyed or isolated by stricturing. Granulomatous masses develop and can simulate malignancy, especially when calcified. Strictures may result in proximal caliectasis with nonopacification. Sonography or CT can identify these dilated structures (Fig. 6).

Ureter (Fig. 7-9)

The ureter is irregular and dilated early in the disease. Irregularity is due to ulcerations. Later the ureter may be thick and shortened. Multiple



Figure 8
Tuberculosis with a characteristic contracted bladder. There was gross vesicoureteral reflux and caliectasis.

strictures are characteristic. An extremely irregular ureter with a beaded or corkscrew appearance is also characteristic (Fig. 7).



Figure 9
This 59 year old woman had symptoms of cystitis for many years prior to the culture of M. tuberculosis from her urine. There is a stricture of the distal ureter (lower arrow) and a calcification in the renal parenchyma (upper arrow). (Courtesy of James Brown, M.D.)

Bladder (Fig. 8, 10)

A small spastic bladder is characteristic (Fig. 8). Focal involvement may produce bizarre shapes. There may be secondary vesicoureteral reflux (Fig. 8). Retrograde pyelography is needed to evaluate the collecting system in a nonfunctioning kidney.

Computed tomography and ultrasonography can be used to evaluate the renal parenchyma and mass lesions. Angiography is of little value in diagnosing or evaluating genitourinary tuberculosis. Complications of tuberculosis include perinephric or psoas abscess and fistulae from the kidney to the colon or duodenum.

Treatment

Multidrug therapy is usually given for 1½-2 years with monitoring of the urine by stain and



Figure 10
Nonspecific trabeculation of the bladder in a woman with known tuberculous infection of the bladder and urethra.

culture and followup excretory urography. Nephrectomy is rarely required.[2,3] ◀

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2. Antman E, Muller J, Goldberg S, et al: Nitedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Pfizer LABORATORIES DIVISION
PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

Please see PROCARDIA *brief summary on adjoining page*

Classified Advertising

All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of $2 will be assessed when a box number is requested.

CLASSIFIED ADVERTISING RATES

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	$6.00	$9.00	$14.00	$20.00
3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

POSITIONS AND PRACTICE

CURRENT OPENINGS FOR PHYSICIANS of all specialties in the Illinois area and nationwide. Opportunities in Solo, Hospital and Clinic based positions. For further information please contact Physicians Recruiters Inc. at (312) 724-7001. All inquiries will be handled on a confidential basis.

FAMILY PRACTITIONER—To locate in Rosiclare, Illinois. 53-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forrest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare, IL. 62982. (618) 285-6634.

ILLINOIS, CHICAGO: EXPERIENCED EMERGENCY PHYSICIANS needed for progressive community hospital. Excellent salary and benefits. Good specialty backup. Send resume to One E. Wacker Dr., Suite 2222, Chicago, IL 60601 or call (312) 661-1457.

SURGEON—Board certified/eligible surgeon needed for service area of 21,000. Generous financial incentive, and customized office space available adjacent to 72-bed JCAH hospital. Economically sound community. Cooperative hospital staff. Contact: E. E. Williams, Administrator, Mendota Community Hospital, Memorial Drive, Mendota, Il. 61342.

CHICAGO AREA MEDICAL CENTER is in the process of building 5 community-oriented satellite facilities to include urgent care, specialty offices, and community education facilities. Emphasis on teaching of health awareness, health education, and stress management to citizenry, in addition to outpatient family practice type of setting. Qualified applicants should have experience in Family Practice or other primary care field, preferrably board certified, and should have an interest in health education. Please send CV in confidence to One East Wacker Dr., Suite 2222, Chicago, IL 60601, or call (312) 661-1457.

EMERGENCY MEDICINE: PART-TIME AND FULL-TIME positions available in over 20 emergency departments located in central and southern Illinois. Earn a competitive income while enjoying the many challenges emergency medicine offers. Flexible scheduling and paid professional liability insurance provided. For complete details write or call Catherine Offut, Spectrum Emergency Care, Inc., 999 Executive Parkway, P.O. Box 27352, St. Louis, MO 63141; 1-800-325-3982.

INTERNIST WANTED—To join three internists. Office building attached to 525 bed hospital; town of 150,000. Near Chicago, Medical school teaching opportunity. Write to Box #1078 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

EXCELLENT OPPORTUNITY in Northwest suburbs for child psychiatrist working part-time or full time in private group practice involving inpatient and outpatient adolescent, child and adult care. Must have inpatient adolescent experience and board eligibility. Please send vitae to Box #1076 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

ASSISTANT DIRECTOR—4 y/o approved community based Family Practice Residency affiliated with Southern Illinois University. Generous salary and fringes for M.D. (board certification highly desirable). Assistant professor or higher rank depending upon background. Administration, teaching and practice responsibilities. Applications accepted until position filled. Reply to: David Ouchterlony, M.D., Director, Decatur Family Practice Center, 1314 N. Main, Suite 201, Decatur, IL 62526 (217) 423-8186. S.I.U. School of Medicine is an Equal Opportunity/Affirmative Action Employer.

MULTISPECIALTY GROUP thirty miles southwest Chicago seeks young board eligible OB/GYN man to join eight man group. Incentive plan, profit sharing, new building. Excellent practice opportunity and schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423 (815) 469-2123.

OTOLARYNGOLOGIST—Excellent opportunity for full or part-time combined practice with ophthalmologist located SW of Chicago. Tuesday and Friday office hours advisable with Thursday surgical day. Write Box 1051 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

OPHTHALMOLOGY/LOCUM TENENS or association—Opportunity for surgical assisting, office, glaucoma management, refraction and eye care located SW of Chicago. Write to Box #1051 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

GENERAL INTERNAL MEDICINE OR FAMILY PRACTICE: with or without sub-specialty; liberal with initial salary and benefits; rapid corporate membership; metropolitan and Chicago area suburb; unlimited potential. Write Box #1074 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

ILLINOIS—BOARD-ELIGIBLE/BOARD CERTIFIED, PEDIATRICIAN to join established practice in community of approximately 100,000; one hour from Chicago. Liberal salary with fringes leading to early professional ownership. Send resumé to: S. B. Granger, M.D., 1300 North Highland, Aurora, Illinois 60506.

PSYCHIATRISTS: CompCare offers board certified psychiatrists opportunity to expand your practice with contractual involvement in our innovative inpatient psychiatric treatment program, which is part of a national careunit system. We operate on a team approach concept, and you will be responsible for the admission and diagnosis of all patients in our care. Choose your location in metropolitan cities and small towns nationwide. Flexible hours that work around your current schedule are available, along with excellent financial compensation commensurate with your experience and credentials. Please send resume or contact: Recruitment Specialist, Comprehensive Care Corporation, 12255 DePaul Dr., Bridgeton, MO 63044 (314) 291-1144.

BOARD ELIGIBLE ANESTHESIOLOGIST. Immediate opening. Established corporation located in Danville, Illinois. Full or part time. Good opportunity for personal financial growth. Contact: William Grant, M.D. Danville Anesthesia Associates, P.O. Box 588, Danville, IL 61832, (217) 443-5629.

ORTHOPEDIC PHYSICIAN for Chicago and northwest suburbs wanted, must be board eligible or certified for evaluation center part-time. Hours flexible. Reply to Box #1081 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

FAMILY MEDICINE AND INTERNAL MEDICINE SPECIALISTS: Medical Placement Assoc. has been commissioned by a midwestern multi-specialty group to seek three additional associates interested in adult medicine, as the principle provider of primary health care for an established HMO (independent group model). This opportunity offers financial and practice security, a lucrative bonus program and an extremely satisfying environment of professionalism. To learn further particulars, call collect (313) 557-3350 or forward your C.V. to: 18877 W. Ten Mile Rd., Southfield, MI 48075.

OUTSTANDING FINANCIAL OPPORTUNITY Internist/GP; pulmonary internist; cardiologist (invasive); 10th wealthiest US city; insurance, pension; relocate $90-$200,000; may buy in. Send resume to Box #1083 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

INTERESTED IN INTERNAL MEDICINE PRACTICE—Will do Treadmeal EKG, Holtez, Echo. Board-Eligible in internal medicine; residency trained. Consider solo, group, partnership or hospital based. Reply Box #1084 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

President's Page

Commencement



For many, the month of June is marked by commencement exercises. To graduates, commencement signifies a new career phase, either further learning or practical application of specific knowledge.

Commencement should give us cause to review with satisfaction our current volunteer system—a system which has provided this nation with an unsurpassed level of health care.

The newly graduated physician has completed a medical education program built upon standards established by the Liaison Committee on Medical Education (LCME). The LCME is made up of representatives from volunteer organizations: the AMA Council on Medical Education and the Association of American Medical Colleges. This group, and its Canadian counterpart, assure a highly respected standard in medical education. We are assured that graduating physicians have a specific data base of knowledge and skills. That data base provides the foundation for advanced training which will eventually enable them to take independent responsibility for patients.

Most physicians proceed to graduate study. The second level of voluntary accreditation is achieved through the Accreditation Council on Graduate Medical Education (ACGME). This body has several corporate parents: the AMA Council on Medical Education, the Association of American Medical Colleges, the American Hospital Association, the Council on Medical Specialty Societies and the American Board of Medical Specialties. A Resident Physician, federal government member and public member add the breadth of input needed to develop essentials for residency training. ACGME's July 1, 1982, implementation of specified essentials for graduate medical education ensures a continuing standard for decades to come.

The time-honored preceptorship principle has been replaced by a combination of established curricula and integrated clinical experiences designed to develop an optimal skill level. The many physicians in contact with graduate medical education programs—either through the hospital medical staff or educational institutions—have a crucial role in this training system. Each must give priority to the educational challenge of working with physicians in training.

Commencement emphasizes the physician's individual responsibility for continuing medical education. Regardless of statutory requirements, the advancement of medical science places the duty of continuing medical education on the shoulders of every practicing physician. Our volunteer system has provided the standards and the resources to meet that demand. Each of us enjoys a wealth of means to fulfill it. In this way, the continuing advancement of our profession and improving standards of health care are assured. ◀

Robert P. Johnson, M.D.

Robert P. Johnson, M.D., President

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

July 11	Carle Clinic	Urbana
July 11	Mercy Center	Aurora
July 18	ANCHOR	Chicago
July 18	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
July 21	American Cancer Society Training	Chicago
August 1	Hinsdale Sanitarium & ACS	Hinsdale
August 15	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
August 18	American Cancer Society Training	Chicago
September 13	Indian Trails Library & ACS	Chicago
September 19	Lutheran General Hosp. & Chicago Lung Assn.	Park Ridge
September 22	American Cancer Society Training	Chicago
October 3	Lake Forest Hosp. & ACS	Lake Forest
October 3	Condell Memorial Hosp. & ACS	Libertyville
October 3	Anchor	Chicago
October 4	St. Francis Hosp. & ACS	Blue Island
October 12	St.Therese Area Trauma Satellite & ACS	Lake Villa
October 17	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
October 20	American Cancer Society Training	Chicago
November 7	Lutheran General Hosp. & Chgo. Lung. Assn.	Park Ridge
November 13	Victory Memorial Hosp. & ACS	Waukegan
December 5	Anchor	Chicago

Brief Summary of Prescribing Information

INDICATIONS — For management of anxiety disorders or short-term relief of symptoms of anxiety: for symptomatic relief of acute alcohol withdrawal: for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

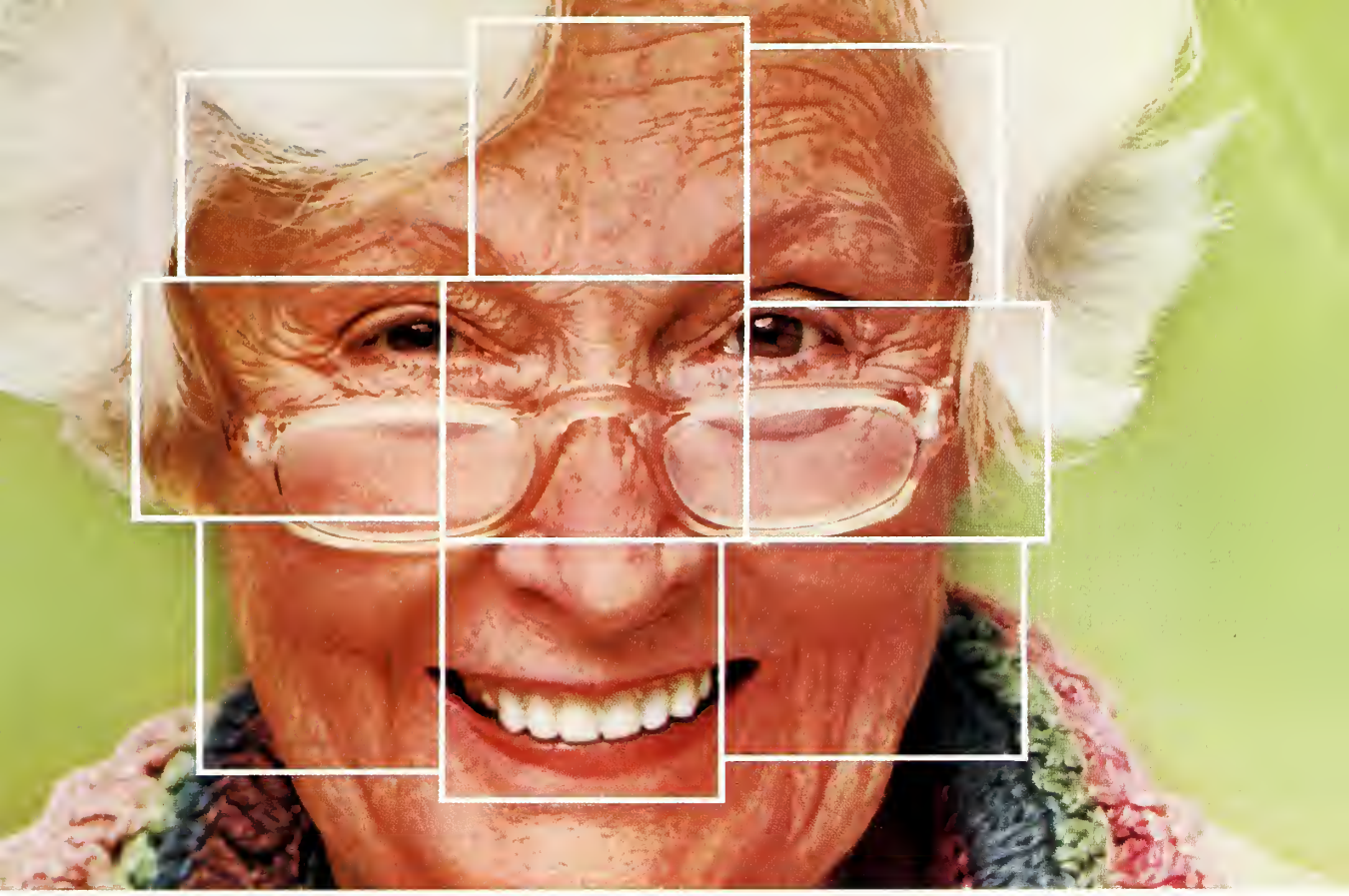
OVERDOSAGE — Take general measures as for any CNS depressant.

SUPPLIED — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

Tranxene®
clorazepate dipotassium Ⓝ
Calms with care

Abbott Pharmaceuticals, Inc.
North Chicago, IL 60064

3023513



During anxiety therapy...

Tranxene calms with a low incidence of problem sedation* and without likelihood of amnesia

In direct comparisons Tranxene has been shown equal to or lower than diazepam[1-9] in incidence of problem sedation.* And although Tranxene studies were not specifically designed to investigate anterograde amnesia, there have been no reports of this problem in the literature in over a decade of clinical use. The Tranxene record is impressive.

*Problem sedation is defined as moderate to severe degrees of sedation, sleepiness; drowsiness, lassitude.

Tranxene®

clorazepate dipotassium Ⓒ IV

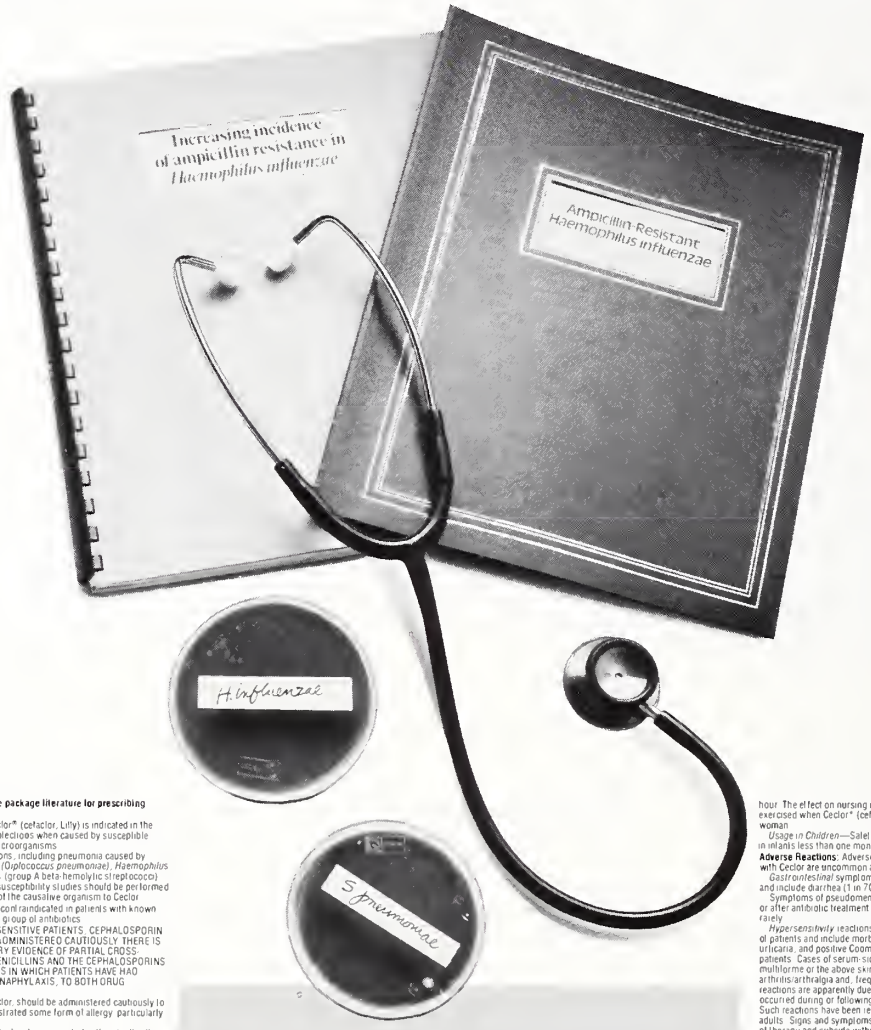
Calms with care

3.75, 7.5, 15 mg capsules, scored tablets; 11.25, 22.5 mg single-dose tablets.
For brief summary, see an adjacent column.

ABBOTT 3053551

1. Barker MA, Davenport RH et al: *Practitioner* 215:98-101, 1975. 2. Cooper AJ, Magnus RV et al: *Br J Psychiatry* 123:475-476, 1973. 3. Feurst SI: *Curr Ther Res* 15:449-459, 1973. 4. Magnus RV: *Br J Clin Pract* 27:449-452, 1973. 5. Magnus RV, Dean BC et al: *Dis Nerv Syst* 38:819-821, 1977. 6. Mielke DH, Gallant DM et al: *Curr Ther Res* 19:506-511, 1976. 7. Ricca JJ: *J Clin Pharmacol* 12:286-290, 1972. 8. Robin A, Curry SH et al: *Psychol Med* 4:388-392, 1974. 9. Wiersum J: *Curr Ther Res* 14:442-448, 1972.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*: 91, 1975
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6. Antimicrob. Agents Chemother., *13*: 861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Lilly

Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

300035

Abstracts of Action

April 21-24, 1983

Palmer House
Chicago, Illinois

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

MEDICAL STUDIES ACT

On April 11, 1983, a ruling in the Circuit Court of Cook County held the Medical Studies Act unconstitutional. This will be reconsidered by the court on June 7. After exploring several options, the Board voted to consider the ruling against the Medical Studies Act an extremely important issue and instructed legal counsel to take the strongest appropriate action to help resolve this issue.

DRGs, PPOs, COST CONTAINMENT

After thorough review, the Council on Economics determined it to be very important that the time now available be used to begin studying the impact of Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs) and Third Party Payer Cost Containment Initiatives. Acting on recommendation of the Council on Economics, the Board authorized the Council to study the variety of private and government sponsored cost containment programs for the purpose of developing a proposed strategy for ISMS to use in effectively representing membership interests in this arena.

PEER REVIEW ORGANIZATIONS

The Third Party Payment Processes Committee recommended that ISMS should actively monitor the development and implementation of Peer Review Organization (PRO) regulations, as well as the activities of groups which apply for PRO designation in Illinois. Acting on the Third Party Payment Processes Committee report, the Board:

- Endorsed the concept of a single peer review organization for Illinois which would have the ability to subcontract its review to appropriate local physician review organizations to ensure that peer review is performed at the local level.
- Agreed not to be directly involved in performing statewide reviews, but rather be available as a facilitator and a resource to appropriate local physician controlled review organizations seeking assistance.
- Directed that the appropriate council or committee review and participate in activities involving development of PRO regulations and the groups which may apply to be the PRO.

REQUEST FOR PROPOSALS

The Illinois Department of Public Aid has received some 28 proposals from interested groups to provide full service medical care to IDPA recipients on a prepaid capitation basis. After reviewing a report from the Third Party Payment Processes Committee, the Board directed that: (1) ISMS nominate physicians to serve as reviewers on the Illinois Department of Public Aid panel to review the full service Request for Proposals; and (2) ISMS include the name of Dr. Arthur R. Traugott in a list of physicians nominated to serve on this IDPA panel.

(Continued on page 443)

HYPERTENSION PROTECTION AND MORE.



START WITH INDERAL® (PROPRANOLOL HCl). THE REASONS HAVE NEVER BEEN BETTER.

INDERAL, a logical first step

Unlike thiazide diuretics, which can provoke serious reductions of serum potassium, INDERAL has been found to maintain or modestly increase serum potassium levels.[1,2] Therefore, the consequences of hypokalemia—including the threat of ventricular arrhythmias[2]—may be significantly reduced.

INDERAL acts to reduce catecholamine-induced "spiking" of blood pressure which often coincides with the physical and emotional stress in a hypertensive's life.[3] INDERAL reduces elevated heart rate, force of ventricular contraction, and cardiac work load—providing smooth control of hypertension to decrease the risk of related cardiovascular complications. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.)

INDERAL works in a way that non-beta blockers can't—to provide long-term cardiovascular benefits.

INDERAL provides treatment for coexisting angina pectoris or cardiac arrhythmias in addition to reducing blood pressure—for comprehensive protection. What's more, INDERAL is well tolerated, acting with few of the distressing side effects of antihypertensive agents such as methyldopa or reserpine. Impotence, depression, sedation, orthostatic hypotension, and nasal stuffiness are rare. (Please see following page for Brief Summary of Prescribing Information, including side effects of INDERAL.)

Indeed, INDERAL has changed the face of antihypertensive therapy, worldwide. And it continues to do so—with an unparalleled record of clinical efficacy and experience.

INDERAL. It's the kind of protection hypertensive patients need—right from the start.

References: 1. Traub, Y. M., *et al.*: Clin. Pharmacol. Ther. *28*:765 (Dec.) 1980. 2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. *647* (Suppl.):67, 1981. 3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

INDERAL®
(PROPRANOLOL HCl)

Comprehensive Cardiovascular Protection

Please see following page for brief summary of prescribing information.

IN HYPERTENSION START WITH

INDERAL®

(PROPRANOLOL HCl)



The appearance of these tablets is a trademark of Ayerst Laboratories.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
Inderal® (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System:* lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings.* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-99).

—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTABLE

—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

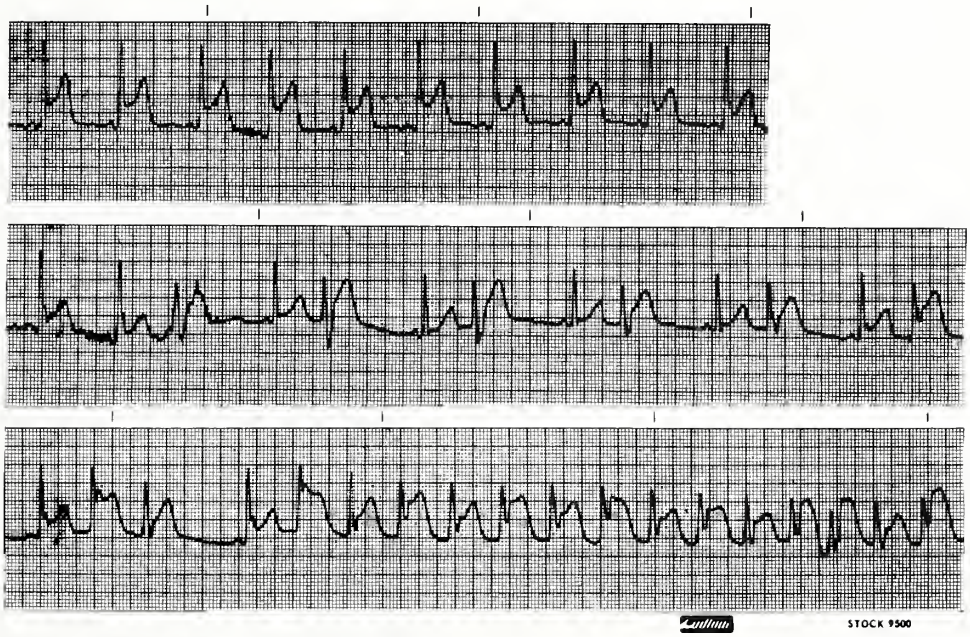
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8229/383

EKG of the Month

CONTRIBUTING EDITORS: JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D., PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D., JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This is a fifty-five year old man who had an uncomplicated myocardial infarction four years ago. He was asymptomatic, working daily, until two weeks ago when the chest pain returned. Four years earlier, the chest pain prior to the infarction had always resulted from some activity but now it occurred at rest. He was also awakened by the pain during the night on several occasions. The chest pain was always relieved by sublingual nitroglycerine but sometimes two tablets were required. On occasion he felt heart palpitations. His physical exam was normal except for a prominent atrial gallop (S_4). A chest X-ray was normal. A resting twelve lead ECG showed an old inferior wall myocardial infarction. The patient was admitted to the hospital in an ECG telemetry unit. The patient had a chest pain when this continuous ECG strip was recorded.



Questions:

1. **The ECG strip shows:**
   a. Cycle dependent bundle branch block.
   b. ST segment elevation.
   c. ST segment elevation with alternans.
   d. Premature ventricular beats with a burst of ventricular tachycardia.
   e. Premature atrial beats with a burst of supraventricular tachycardia.

2. **Which of the following statement(s) is/are true?**
   a. This patient has unstable angina.
   b. Coronary angiography is indicated in this case.
   c. Coronary vasopasm is thought to be a prominent component of the problem.
   d. This syndrome is associated with arrhythmias and even myocardial infarction.
   e. All of the above.

(Continued on page 408)

Obituaries

****Collins, Nathan P.,** Elgin, died April 22, 1983 at the age of 79. Dr. Collins was a 1929 graduate of Eclectic Medical College, Cincinnati.

***D'Silva, Joseph L.,** Wilmette, died April 26, 1983 at the age of 61. Dr. D'Silva was a 1948 graduate of the Stanley Medical College, Madras University, Madras.

***Evanson, Peter,** Rockford, died March 28, 1983 at the age of 45. Dr. Evanson was a 1963 graduate of the University of Illinois College of Medicine, Chicago.

***Hall, Richard E.,** Westmont, died April 21, 1983 at the age of 60. Dr. Hall was a 1946 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Jones, Ralph E.,** Chicago, died April 26, 1983 at the age of 81. Dr. Jones was a 1929 graduate of Rush Medical College, Chicago.

****Meltzer, Herman L.,** Clinton, died September 23, 1982 at the age of 74. Dr. Meltzer was a 1931 graduate of Northwestern University Medical School, Chicago.

***Sanders, Orland M.,** Centralia, died March 11, 1983 at the age of 74. Dr. Sanders was a 1935 graduate of the Kansas City University of Physicians and Surgeons.

***Smith, Warren F.,** died April 8, 1983 at the age of 66. Dr. Smith was a 1943 graduate of Loyola University Stritch School of Medicine, Maywood.

***Smyth, W. Patrick,** River Forest, died April 3, 1983 at the age of 47. Dr. Smyth was a 1964 graduate of Northwestern University Medical School, Chicago.

****Snitman, Maurice F.,** Wheaton, died April 6, 1983 at the age of 78. Dr. Snitman was a 1926 graduate of the University of Toronto Faculty of Medicine, Toronto.

****Strause, Clifford P.,** Peoria, died April 4, 1983 at the age of 86. Dr. Strause was a 1921 graduate of Rush Medical College, Chicago.

****Waldo, Proctor C.,** Phoenix, Arizona, died April 10, 1983 at the age of 88. Dr. Waldo was a 1920 graduate of Rush Medical College, Chicago.

***Yonan, John Baaba,** Chicago, died February 21, 1983 at the age of 81. Dr. Yonan was a 1934 graduate of Loyola University Stritch School of Medicine, Maywood.

**Indicates ISMS member.*
***Indicates member of Fifty Year Club.*

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Pfizer LABORATORIES DIVISION
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

[*] Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

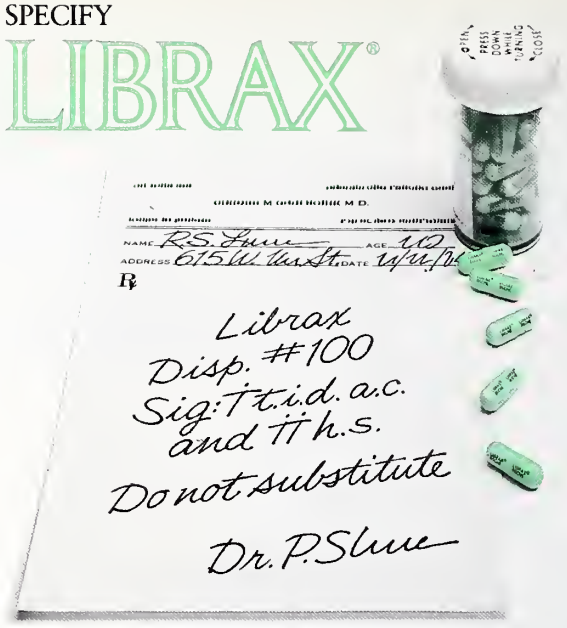
Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal,* however, will secure author permission before authorizing a reprint.

SPECIFY
LIBRAX®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

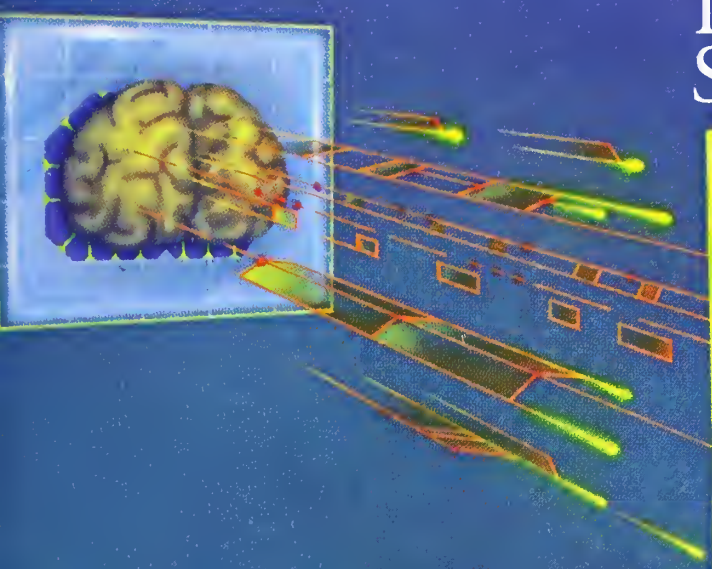
Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

PATHWAYS TO IRRITABLE BOWEL SYNDROME*





Illustrated here is the connection between emotional anxiety and the altered state of intestinal motility of irritable bowel syndrome.[1-3] While no abnormalities may be seen after physical examination or blood tests on these patients,[2] the slow rhythms of their intestines have been found to be more prominent than normal when they are symptomatic *and* when they are symptom-free.[3]

PATHWAYS TO TREATMENT
...OF THE EMOTIONAL AND PHYSICAL FACTORS

THE ANTIANXIETY ACTION OF LIBRIUM® (chlordiazepoxide HCl/Roche)

The presence of Librium in the Librax combination serves as a calming agent for the patient with irritable bowel syndrome. Librium has an unequaled record of efficacy and safety and seldom impairs mental acuity. Patients should be cautioned, however, about taking any CNS-acting agent while performing activities that are hazardous or require complete mental alertness.

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The Quarzan in Librax provides anticholinergic action that can aid in the control of hypersecretion and irregular intestinal motility to relieve the distressing abdominal symptoms of irritable bowel syndrome.

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

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*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of irritable bowel syndrome.
Please see brief summary of prescribing information on preceding page.

References: 1. Sandler RS, Drossman DA: *Intern Med 2*(1):39-47, Jan 1981. 2. Mendeloff AI: *Practical Gastroenterol 3*(3):12-18, May-Jun 1979. 3. Connell AM: *The Female Patient 5*(9):20-22, Sep 1980.

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The Viewbox

CONTRIBUTING EDITOR TERRENCE DEMOS, M.D., ASSOCIATE PROFESSOR OF RADIOLOGY,
DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was submitted by Richard Cardella, M.D., department of radiology, Loyola University Medical Center, Maywood.

A 27 year old non-smoking male has lost 10 pounds in 2 months and fatigues easily. Past history is negative. On physical examination the only positive finding is diplopia at extremes of lateral gaze. His chest radiograph is abnormal.



Figure 1
PA chest X-ray shows fullness of the mediastinum and right hilar area, and linear density over the left mid lung field.

Your diagnosis?

(a) Lymphoma
(b) Teratoma
(c) Substernal thyroid
(d) Thymoma
(e) Sarcoidosis

What would your next step be?

(a) Esophogram
(b) Conventional tomography
(c) Computed tomography
(d) Gallium scan
(e) Angiogram

(Continued on page 437)

Hypertension In Blacks: Some New Perspectives.

A Symposium.



Co-Chairmen:
Elijah Saunders, M.D.
Provident Hospital, Inc.
Baltimore, Maryland

Richard A. Williams, M.D.
Wadsworth Veterans Administration
Medical Center
Los Angeles, California

This program will cover the epidemiology, pathophysiology of hypertension and a review of current antihypertensive therapy. In addition, the results of ongoing clinical studies of a new antihypertensive agent will be presented.

---

12 Noon—1:00 Brunch
1:00 pm —5:00 Symposium
5:00 pm —6:00 Reception

Sunday, July 31, 1983
Downtown Chicago Marriott
540 N. Michigan Avenue
Chicago, Illinois

Presented by the Association of Black Cardiologists. Sponsored by Schering Corporation as a Continuing Medical Education Service.

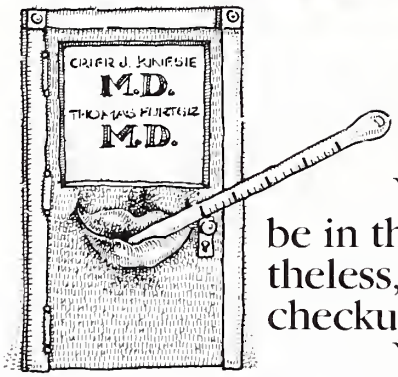
Accreditation
As an organization accredited for continuing medical education, Provident Hospital, Inc. designates this continuing medical education activity as meeting the criteria for 4 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association.

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Pulse of the ISMS Auxiliary

Membership

By Susanne Webb, Edwardsville/President, ISMSA

Why should I be a member of ISMSA? What benefits do I derive from federated membership in the county, state and national auxiliaries? These are questions asked with increasing frequency and rightly so. With the pace of life seeming to increase with every year, the volunteer must be selective in where she chooses to donote her time and talents. Any group needing volunteers must demonstrate that there are worthwhile rewards to be gained from membership.

The medical auxiliary is a unique group in which only doctors' spouses qualify for membership. It offers an avenue for the spouse to be of personal assistance to the doctor by being a positive force in the community working to improve the quality of life and health care locally. It projects an image of "a pair who care."

Doctors' spouses can form support teams for each other because they understand the special problems of the medical family. This is very important in these increasingly stressful times. We all need to be able to let off steam without the fear of being misunderstood.

The state auxiliary's job is to coordinate county activities and provide leadership and leadership training. We can also provide legislation updates on bills of concern to medicine so that we, as individuals and as groups, can influence legislation which will have an impact on our lives. Utilize your state officers and chairmen; ask them for assistance in planning programs and projects.

The national auxiliary provides numerous materials, at no charge, for our use. These include brochures on many topics, package programs on ten health care topics and the project bank book, which is filled with ideas and projects developed by individual counties.

They also provide excellent leadership training for county presidents-elect at fall confluence—ask anyone who has been there. The regional cluster meeting in February provides valuable leadership training for state presidents and presidents-elect and also affords them the opportunity to meet their counterparts from other states and share ideas.

I urge that spouses belong to all three auxiliaries to form one federation. This enables the auxilian to assist his/her spouse and serve the local community with maximum effectiveness. This is your organization—help it to serve your needs and those of your community. ◀

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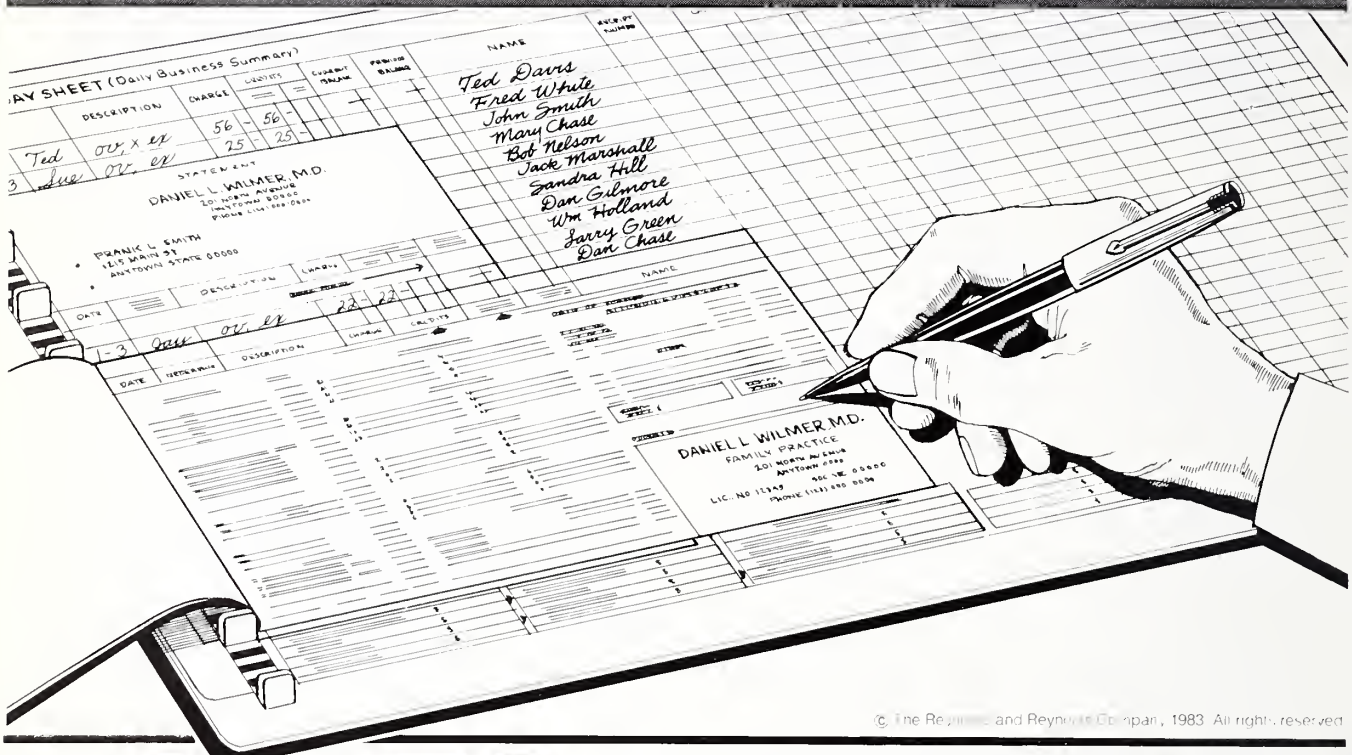
August-October 1983

Specialty Review in Emergency Medicine
August 1-6
Specialty Review in Internal Medicine, Certifying
August 7-13
Specialty Review in General Surgery, Part II
August 15-26
Fiberoptic Colonoscopy
August 24-26
October 5-7
Endourology and Uretero-pyeloscopy
August 26-27
Fiberoptic Esophogogostric Endoscopy
August 29-31
October 10-12
Specialty Review in Neonatology/Perinatology
August 29-September 2
Specialty Review in Gastroenterology
September 19-23
Specialty Review in Medical Oncology
September 19-23
Specialty Review in Endocrinology and Metabolism
September 19-23
Specialty Review in Dermatology
September 26-30
Specialty Review in Pathology: Anatomic
September 26-October 1
Specialty Review in Pathology: Clinical
October 3-7
Specialty Review in Cardiovascular Disease
October 10-14
Contemporary Topics in Psychiatry
October 10-14
Contemporary Topics in Neurology
October 17-21
Specialty Review in Obstetrics and Gynecology: Practical Aspects
October 17-22
Specialty Review in General Surgery, Part I
October 24-November 4
Critical Care Medicine
October 24-28
Specialty Review in Peripheral Vascular Surgery
October 31-November 4

For further information, write or call:

The Cook County Graduate School of Medicine
707 South Wood Street
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(312) 733-2800.

Your bookkeeper/office manager will be interested in this!



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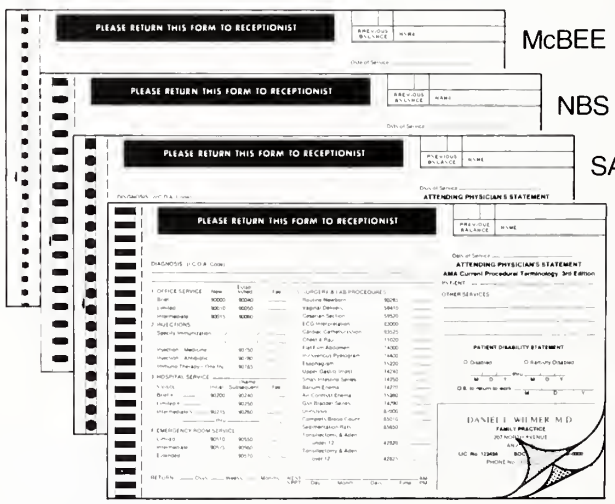
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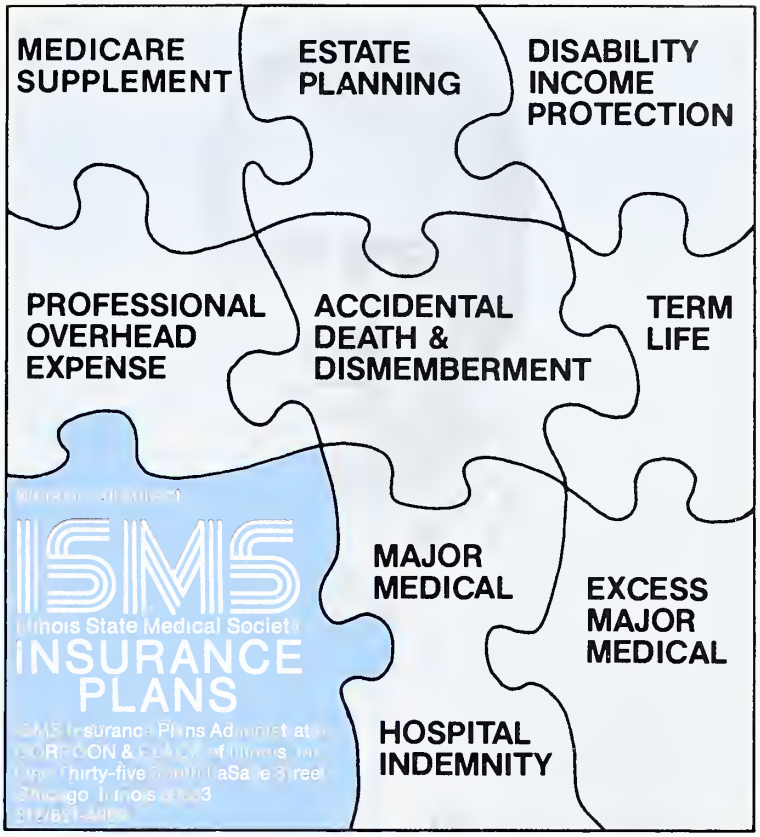
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Illinois Society, American Association of Medical Assistants

Meet The New President

On Saturday, April 23, 1983, Betty Kronemeyer, CMA, was installed as the 1983-84 president of Illinois Society, American Association of Medical Assistants. Betty Burkhart, a close friend, was installing officer and Dr. L. Walk was master of ceremonies at the Continental Regency Hotel in Peoria.

This meeting was hosted by the Peoria Chapter and was Illinois Society's 27th annual meeting.

Mrs. Kronemeyer has been a member of St. Clair Chapter since 1974 where she has served as corresponding secretary, recording secretary, vice president, president and councilor to Illinois Society. She chaired and served on many committees including the symposium committee. She received Illinois Society's outstanding service award in 1978.

Illinois Society offices held to date by Mrs. Kronemeyer include: chairman of legislation and nominating committees and first vice-president. She has also been a delegate to the American Association of Medical Assistants' annual meeting.

She has served on Belleville Area College's Medical Advisory Committee for six years and taught a medical insurance and management class there for two years.

She is an active member of St. Martin of Tours Lutheran Church in Mascoutah, Illinois and served as president of their Ladies Guild for two years. She also works with the Women in Mission group and sings in the choir.

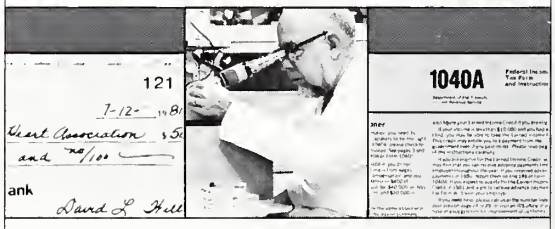
While her husband, David, three daughters and four grandchildren occupy many hours of her time she also includes swimming, crafts, music and butterfly collecting as hobbies. She has also found time to work as hostess at "Diamond Lil's Restaurant" in Belleville, Illinois.

She has been employed for the past ten years by Plastic Surgery Consultants, LTD. in Belleville. They have been supportive of her work with Illinois Society in the past and have promised to continue to do so.

Illinois Society looks forward to another productive and energetic year under Mrs. Kronemeyer's leadership.

Further information regarding Illinois Society, the American Association of Medical Assistants may be obtained from Betty Kronemeyer, CMA, President, Illinois Society, 809 North Tenth Street, Mascoutah, Illinois 62258, or Lesa Greene, CMA-C, Chairman, Public Relations Committee, 8836 W. Grand Ave., River Grove, IL. 60171. ◂

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Your contribution of money or securities to the American Heart Association's Pooled Income Fund can yield:

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For free information about the pooled income fund and other estate planning programs, contact the American Heart Association, 1181 North Dirksen Parkway, P.O. Box 2666, Springfield, Illinois 62708. (217) 525-1350.

American Heart Association
WE'RE FIGHTING FOR YOUR LIFE

Information Available On Child Car Restraints

Physicians can take an active role in helping parents comply with the Illinois Child Passenger Restraint Act, which takes effect July 1, 1983.

The act, which requires parents to secure their small children in child passenger restraint devices, was signed into law last year. In conjunction with the implementation of the act, Gov. James R. Thompson has designated June 26-July 2 as Child Passenger Safety Week.

A pamphlet published by the Illinois Child Passenger Safety Association (ICPSA) lists a number of suggestions physicians and practitioners may consider to increase public awareness on this topic. Physicians can receive the pamphlet and more information from ICPSA by writing the group at PO Box 161, Elk Grove Village, IL., 60007.

Brochures on child car restraints that physicians can offer patients are available from the Illinois State Medical Society. The brochure explains why restraints are needed, provides a "shopping list" of several crash-tested devices on the market and shows how the devices should be properly used. A packet of 100 brochures is available for $16. Checks should be made payable to "Illinois State Medical Society—Car Seats" and sent to the Society's Division of Medical Services, 55 E. Monroe, Suite 3510, Chicago, IL., 60603.

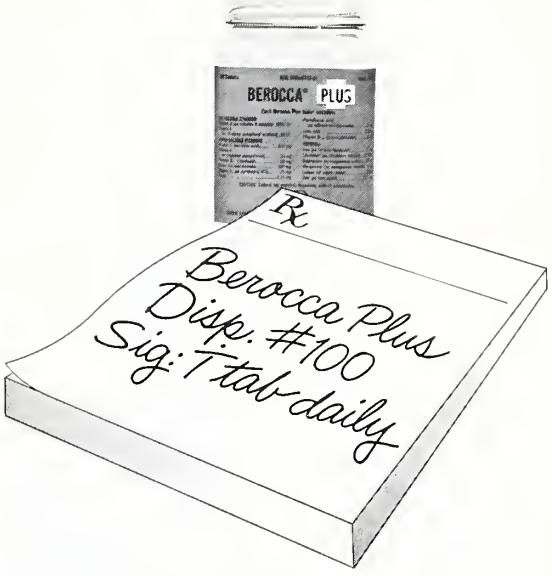
Physicians also may participate in the statewide Child Passenger Safety Conference on September 9-10, 1983. The conference is co-sponsored by the ICPSA, ISMS, the Illinois Chapter of the American Academy of Pediatrics and others. Conference topics will include behavior modification to encourage children to use car seats and educational programs for hospitals and groups regarding child safety.

Further information on the conference can be obtained by contacting the state medical society's Division of Medical Services at 312-782-1654. ◀

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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General.* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient.* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

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1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1114

Please see summary of product information on reverse page.

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EKG

(Continued from page 395)

Answers: 1. B, C, D
2. E

This patient has an unstable angina which occurs at rest and is accompanied by ST segment elevation. This is Prinzmetal's variant angina. The ST segment elevation varies on a beat to beat basis. Alternation of ST segment elevation is best seen in line three. ST segment alternans is uncommon even in variant angina and suggests a temporal dispersion of refractoriness with the ischemia and chest pain. This could cause a fractionation of the wavefront in depolarization and lead to a reentry tachycardia.[1] Indeed, the premature beats in line two are not preceded by a P wave and the cycle containing the premature beat is equal to two sinus cycles in line one. In other words, this cycle is the compensatory pause of premature ventricular beats. The coupling interval of the premature ventricular beats in line two is equal to the cycle length of the beats in the tachycardia in line three. The QRS morphology of the beats in the tachycardia resembles the morphology of the premature ventricular beats. This is ventricular tachycardia. Variant angina has been associated with ventricular tachycardia, ventricular fibrillation, and myocardial infarction. Coronary angiography is indicated here. Variant angina has occurred in patients with single vessel coronary disease, multivessel disease, and normal coronary arteries. Coronary vasospasm is thought to play an important role in this syndrome. The vasospasm may occur in normal arteries or more commonly in the presence of fixed atherosclerotic obstruction. Therefore, calcium channel blocking drugs, such as nifedipine, have been useful here. Selzer[2] and his associates have separated variant angina in patients with normal coronary arteries from those patients with atherosclerotic coronary disease. Patients with variant angina and normal coronary arteries tended to have a long history of non-exertional, mostly nocturnal angina, without any history of exertional angina or myocardial infarction. In contrast, patients with obstructive coronary disease had a history of recent onset unstable angina often preceded by exertional angina and myocardial infarction. These patients with coronary disease also had a higher incidence of ventricular tachycardia and fibrillation. Our patient had triple vessel coronary artery disease. Nifedipine and nitroglycerine helped control the attacks of variant angina. ◀

References

1. Kleinfeld, Morris J., Rozanski, John J.: Alternans of the ST Segment in Prinzmetal's Angina, *Circulation* 55:574-577, 1977.
2. Selzer, Arthur, Langston, Manley, Ruggeroli, Charles, Cohn, Keith: Clinical Syndrome of Variant Angina with Normal Coronary Arteriogram. *New England J of Med* 295:1343-1347, 1976.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Family Practitioner. Excellent practice opportunity. Join young group of board-certified internists, family practitioners providing comprehensive health care in beautiful, wooded southern Illinois. Office adjacent to community hospital. Major state university (20 miles away), with medical school offers opportunity for affiliation. Administrative support provided. Guaranteed salary, bonus, fringes. Contact Susan Casey, Rural Health, Inc., 517 North Main Street, Anna, 62906 (618-833-4471). (8)

CAIRO: Seeking Emergency Medicine, Internist, and/or Family Practitioner to join multi-specialty medical group serving two-county area (pop. 20,000). Sixty miles south of Carbondale. Complete office facilities available with financial assistance. Outdoor recreation abundant. Contact: Steve Miller, Director, 529 Cross Street, Cairo 62914 (618-734-4200). (8)

DYER, IN: Two board certified/eligible psychiatrists to establish practice in our service area: (1) Private practice with contractual arrangement in substance abuse program and (2) adult private practice with minimal guarantee until practice is established. Contact: Professional Recruiter, Our Lady of Mercy Hospital, U.S. Hwy. 30, Dyer, Indiana 46311 (219) 865-2141 (8)

FAMILY PHYSICIAN: University clinics, the Chicago Medical School. Board certified specialist in family medicine for full-time ambulatory clinical practice. Faculty appointment, medical administrative responsibilities, work closely with clinics administrator. Substantial benefits package, malpractice insurance paid. Send C.V. to: T.M. Robertson, Clinics Administrator, University Clinics, 3333 Green Bay Road, North Chicago, 60064, or telephone (312) 578-3244. (10)

GIBSON CITY: Cardiologist, internist wanted to join expanding multi-specialty medical staff associated with modern well equipped hospital; ICU capable of invasive monitoring; attached privately funded SNF; new professional office space available; rural community in east central Illinois within 30 minutes of major universities, tertiary care centers, metropolitan areas with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City, 60936 (217/784-4251). (7)

With Any Luck, You'll Never Know How Good Your Malpractice Insurer Is.

The only true test of your professional liability insurer comes when you're sued. It's then that you'll learn whether the company has your interests in mind as it works to resolve the claim.

Since the Illinois State Medical Inter-Insurance Exchange is owned and controlled by its physician policyholders, it looks out for their interests. Unlike some commercial insurers, the Exchange is committed to defending suits that have no merit—even if settlement would be more expedient. And the Exchange will not settle a claim without physician participation.

But defense of claims is only part of the story. The Exchange constantly strives to make its program responsive to all participants. That's why the Exchange establishes a classification and rate structure based upon individual specialty practice modalities and loss experience qualifications.

The Exchange recently completed a comprehensive restructuring of its underwriting and rating program to reflect this equitable approach to professional liability protection. And Exchange policyholders are individually evaluated through a comprehensive review of their practice circumstances rather than simply placed in a particular risk category based solely upon medical specialty designation.

As long as the present legal climate persists, you can continue to expect premium increases from all professional liability insurers. In fact, more claims and higher settlements forced the Exchange to raise premiums for the 1983-84 policy year. But as a policyholder of the Exchange, you can be assured that your own insurance company is working hard to resolve the current claims situation through such activities as aggressive claims defense, legislative initiatives, and education programs designed to reduce potential loss exposure.



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Membership Forum

Membership Forum is intended to serve as a communication tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

An Open Letter To All Physicians With Physical Disability

For the past two years, we have been involved in compiling a resource directory for physicians with physical disability. The work is funded by a grant from the St. Paul-Ramsey Hospital Medical Education and Research Foundation. The purpose of the project is to list physicians with various physical disabilities who are willing to provide information and referral services to physicians who incur the same disability and need specific information. Existing rehabilitation programs are simply not equipped to deal with the situation.

The biggest problem we are encountering is poor participation. It is currently estimated that 4% of all physicians are not in active practice because of a physically disabling condition, and that 25% of these physicians have the potential to be rehabilitated into active practice. In real numbers this constitutes 1% of the licensed physicians in this country or 4,500 physicians. Our goal is to identify these physicians and encourage their participation. To date we have placed advertisements in over 100 major medical journals and have had response from less than 200 physicians. In retrospect, it appears this was due to the use of inappropriate terminology in the ads. Physical disability does not imply inability. Our use of the term "handicapped physician" was inappropriate since the majority of physically disabled physicians are not handicapped in their practice of medicine. We apologize for the inappropriate terminology and again ask that all physicians, active or inactive, with any type of physical disability contact Dr. Zondlo, St. Paul-Ramsey Hospital Medical and Educational Research Foundation, 640 Jackson St., St. Paul, MN 55101. The directory will be completed soon and will be sent to only those physicians who are listed therein. Upon receipt of your initial response, information forms will be mailed. All correspondence is confidential.

All physicians with physical disability, no matter how small, are encouraged to respond. Information from a doctor with even a minor disability may be of value to another doctor with multiple disabilities. The cornerstone of this project is your participation.

Frank Zondlo, M.D.
St. Paul, MN.

Etymologically Speaking

In reading the September 1982 number (162:3, p. 197) I encountered the article on ankylosing spondylitis. In the discussion, the author has the following:

"Ankylosing Spondylitis (latin: Bent Vertebrae)." If erudition is needed in such an article, it should be correct. The proper designation is Latin, with a capital L but the fact is that these words are from Greek, not Latin! Ankylosing comes from the word which means bent or crooked or hook-formed; Spondylitis is a compounded word arising from the word for vertebrae and the suffix meaning inflammation. So the parenthesis should have been (Greek: inflammation of the vertebra causing bending).

Very truly yours,
Oscar Sugar, M.D.
Chicago

On the Liability Crisis A Search for Reasons

Sir:

Recently, we have received in the mail Volume 1, Number 1, of "Antidote." This publication of the ISMS tries to help its members to cope with the liability crisis. The Society also offers seminars and conferences to inform and educate. But the crisis is deepening. Something is wrong with our approach and defenses.

What is wrong with this profession? Nothing as I see it. The quality of physicians graduating from medical school is the finest ever. We have a postgraduate educational program second to none. This nation became the Mecca of medicine. Our leadership is unquestionable. The liability crisis can not be the result of a defect

in the American medical profession or health industry. But there are other important facts. Reviewing the medical liability management in other countries, it is noted immediately that the liability crisis is strictly an American social disease, the disease of a wealthy nation. Many physicians pay more liability premium then the yearly income of most physicians in other countries. This immense personal liability is imposed selectively on the medical profession. The roots of the liability crisis are not in the health industry. They are in our legal system. It cannot be corrected by more CME, relicensing or recertifying. The liability crisis can be resolved only by judicial reform.

Organized medicine is still reluctant to demand judicial reform. But we have very good reasons and justification to ask several constitutional and legal questions.

If we are equal before the law, how is it that the immense personal liability is imposed only on this profession?

How is it that the courts, alleged guardians of constitutional principles, find it proper to allow and even encourage the profitable exploitation of this vulnerable profession?

Is conflict of interest a dead principle in our government? How is it that our legislative bodies, dominated by lawyers, can pass laws for their own financial benefit? The principle of "sovereign immunity" only protects professional incompetence and lack of integrity. How is it that the legal establishment can exclude itself from the great personal liability by clever legal tricks?

The "Antidote" is another noble effort of the Society but it does not get to the root of the crisis. We have to turn more and more to political activism.

Sincerely,
James Scott, M.D.
Streator

The Chairman Responds

Dear Dr. Scott:

Your letter to the *IMJ* "Membership Forum" column has been forwarded to me for response. Your comments regarding our first issue of "Antidote," struck a familiar chord. I'd like to address your concerns and also to encourage your decision to share your feelings with the ISMS membership.

The Committee on Loss Prevention Education established "Antidote," both to provoke thought and to encourage behavioral change. I agree with your assessment that judicial reform is a key aspect in this area. The "Antidote" is not intended to avoid that issue; rather it seeks to address those areas on which we can have the most impact. Clearly, we can affect the professional behavior and awareness of our colleagues far more readily than we can change the thinking of those who may not share the same perspective.

I'd like to gain your input as to how we might effectively act to bring about the judicial reforms cited in your letter. I understand that both your original letter and this response will be published in the *IMJ* "Membership Forum," column. Let's hope that they provoke some thoughtful comment.

Sincerely,
Alfred J. Clementi, M.D.
Chairman,
ISMS *ad hoc* Committee
on Loss Prevention Education



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IMJ
Illinois Medical Journal
Volume 163, No. 6, June 1983

Part I: Strategies To Reduce Infant Mortality

Approaches To Reducing Infant Mortality In Illinois

By Bernard J. Turnock, M.D., M.P.H. And
Laurilynn McGill, M.P.H. Chicago And Springfield

Although the infant mortality rate for Illinois decreased by one-third between 1970 and 1980, the Illinois rate remains 18% higher than the comparable national figure. Three public health strategies seek to address infant mortality through their impact on either the neonatal or postneonatal components of infant mortality. The provision of preconception and prenatal health care acts to lower neonatal mortality by reducing the proportion of low birthweight infants among all births. Perinatal health care services also serve to reduce neonatal mortality, but act through improving birthweight-specific survival rates. On the other hand, infant follow-up services and health supervision during the first year of life exert their impact on postneonatal mortality. Selective application of one or more of these approaches can be facilitated by analysis of the relative contribution of the birthweight distribution, birthweight-adjusted mortality rates, and postneonatal deaths to the total level of excess infant deaths occurring in a service area. A broader perspective of perinatal health care systems encompasses all three strategies, and represents the most promising approach for maximizing perinatal outcomes in the future.

In 1980, the infant mortality rate for residents of Illinois was 14.7 deaths per 1000 live births (Table 1). Nationally, the comparable figure was 12.5 deaths per 1000 live births. The gap between the national and Illinois rates has actually been increasing in recent years, both in absolute and percentage terms.

The Governor, the Department of Public Health and the Statewide Health Coordinating Council have all sought to focus public attention on the high rate of infant mortality in Illinois. Numerous reports of the high Illinois rates have appeared in the media, and considerable research has been initiated to help explain why this situation persists. This high level of interest has caused public policy makers, as well as providers and consumers of health services, to question the effectiveness of current efforts and the wisdom of extension or expansion of today's programs.

Infant mortality has been a major social policy issue throughout this century. Although much is known and written about this public health prob-

Table 1
Infant Mortality Rates Per 1,000 Births by Age and Race
U.S., Illinois, Chicago, and Downstate, 1980

	Total			White			Nonwhite		
	Under 1 Year	Under 28 Days	28-364 Days	Under 1 Year	Under 28 Days	28-364 Days	Under 1 Year	Under 28 Days	28-364 Days
U.S. (Provisional)	12.5	8.4	4.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Illinois	14.7	9.9	4.7	11.6	8.1	3.5	24.6	15.8	8.8
Chicago	20.7	13.2	7.4	14.8	9.8	5.0	25.9	16.3	9.6
Downstate	12.1	8.5	3.6	10.8	7.7	3.1	21.9	14.9	7.1

n.a.—not available
Source: U.S. 1980 provisional figures based on 10% sample, U.S. National Center for Health Statistics
Illinois data from Illinois Department of Public Health

lem, there is little evidence to suggest that public program efforts have significantly reduced infant mortality rates.

Nevertheless, the infant mortality rate in Illinois has dropped 32% since 1970 and the neonatal mortality rate has decreased 40%. The 1980 infant mortality rate for Illinois (excluding Chicago) is actually lower than the national average of 12.5 deaths per 1000 live births (Table 1).

Determinants of Infant Mortality

The crude infant mortality rate is the indicator most commonly used as the measure of success or failure for programs serving mothers and children. Yet, even among those who carefully monitor this important indicator, few understand how it responds to changes in population characteristics or in specific programs designed to reduce the infant mortality rate.

To facilitate analyses of infant mortality, it is often useful to break out deaths in the first 28 days of life (neonatal mortality) from deaths during the remainder of the first year of life (postneonatal mortality).

It should be noted that neither infant mortality nor even neonatal mortality rates represent the most meaningful indicator of successful pregnancy outcome. A considerably better indicator is a perinatal mortality rate which includes fetal deaths occurring after 20 weeks gestation in addition to all neonatal deaths. Infant mortality rates remain the most commonly used indicator of perinatal health status.

The health care literature is replete with literally hundreds of studies relating dozens of variables to poor pregnancy outcomes. This information is of little use in developing strategies for reducing morbidity and mortality unless the relationship between these factors and poor outcomes is better understood.

This discussion will review in some detail the relationships between these risk factors and the larger of infant mortality's two components, neonatal mortality. Postneonatal mortality will be addressed later in this review.

Neonatal Mortality

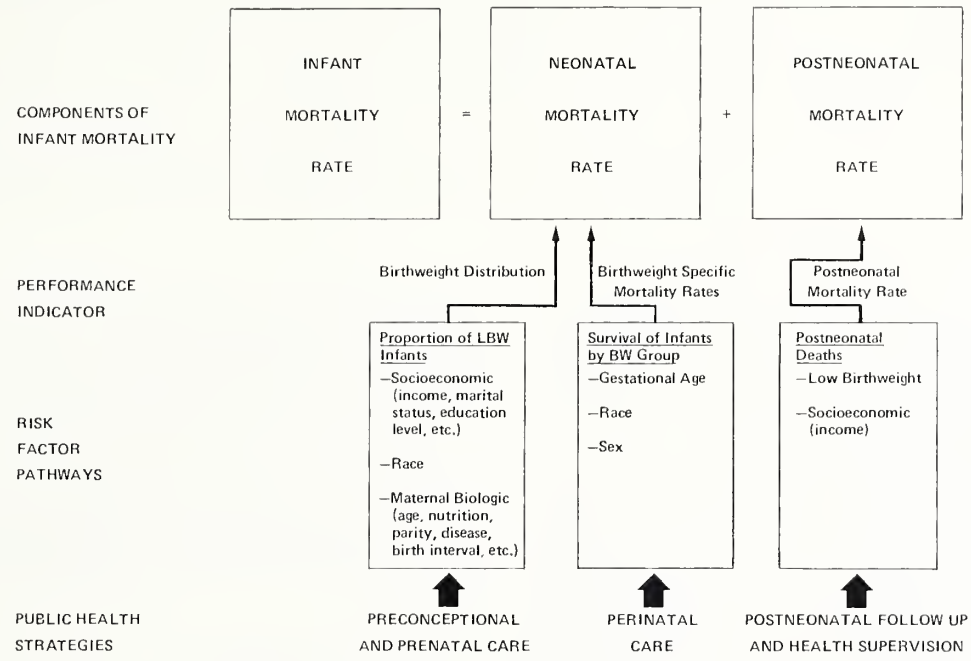
A number of socioeconomic and biologic characteristics have been associated with poor pregnancy outcome and infant mortality. These include *socioeconomic characteristics:* income, education and marital status; *maternal biologic characteristics:* age, parity, nutrition, maternal disease, birth interval, previous reproductive history, smoking, use of alcohol, drug use and weight gain; and finally, *fetal/infant biologic characteristics:* sex, gestational age, birthweight and race.

Reductions in neonatal mortality can be achieved through decreasing the proportion of low birthweight infants born and through improving the survival rates of these infants.[1] The majority of the well known risk factors affect neonatal mortality by altering the proportion of low birthweight infants born.[2] Such risk factors include socioeconomic status, (income, education and marital status) race, and maternal biologic characteristics (such as age, parity, nutrition, disease, birth interval, smoking, drug use, weight gain, etc.). Factors influencing survival within a given weight group include gestational age, race and sex. Figure 1 illustrates the pathways through which these factors affect neonatal mortality rates.

Interventions designed to address high risk factors relating to socioeconomic status or maternal biologic characteristics serve to reduce neonatal mortality indirectly by producing a more favorable birthweight distribution. Interventions addressing fetal/infant biologic risk characteristics act directly by improving survival rates among birthweight groupings of infants. Both "better babies," result-

FIGURE 1

DETERMINANTS OF INFANT MORTALITY



ing from improvements in the risk status of the population, and "better care" can contribute to better outcomes.[3,4]

Neonatal Mortality and Birthweight Distribution

How can health care programs intervene in this model? It is clear that for those factors contributing to the production of low birthweight infants, health care programs alone cannot directly address the race, marital status, educational level, or socioeconomic status of the population giving birth. However, health care programs can address certain maternal biologic factors, through the provision of preconception and prenatal care services, including nutritional supplements. There is considerable documentation that provision of prenatal and preconceptional care services can significantly reduce additional risks associated with these factors. However, it must be emphasized that this risk differential cannot be eliminated.[5-9]

The small reduction (3%) in the overall low birthweight rates for Illinois between 1960 and 1980 suggests that preconception and prenatal care services have been minimally effective to date. Yet the birthweight distributions for both white and nonwhite have moved toward favorable (*i.e.*, higher) birthweights since 1965, except for the very lowest weight categories among nonwhites. It has been the steadily increasing proportion of nonwhite births among all Illinois births, together with the nearly twofold differential in low birthweight rates between nonwhite and white, that accounts for the less than expected reductions in overall low birthweight rates for the state.

Illinois' poor ranking for infant deaths suggests that the prevalence of high risk factors in our state is becoming more unfavorable when compared with other states over this period of time. Substantial evidence supports this possibility.[10]

While the proportion of nonwhite births among all live births has increased both nationally and in Illinois, the rate of increase in Illinois has been about two times greater than the national rate of increase since 1961 (Table 2). While the low birthweight rate among Illinois nonwhites is 10% higher than the national average for nonwhites, it is decreasing at such a slow rate that it lags 15 years behind the national rate.

Table 2
Selected Risk Characteristics for U.S. and Illinois Births, 1961 and 1976

Percent of All Births	United States 1961	United States 1976	United States Pct Change	Illinois 1961	Illinois 1976	Illinois Pct Change	Percent Difference Ill vs. US 1976
To Nonwhites	15.6	18.9	+21	16.5	23.0	+39	+22
Out of Wedlock	5.6	14.8	+164	6.6	19.4	+194	+31
To Women Under Age 19	14.3	18.0	+26	12.7	17.5	+38	−3
Of High Parity (4 or more)	29.4	11.0	−63	30.7	12.2	−60	+11

Source: Tabulations in Illinois Department of Public Health

Illinois is one of only six states that experienced a significant increase in the percent of children living in poverty between 1969 and 1975.[11] Five of these six states, including Illinois, experienced a decrease in infant mortality rates less than the U.S. rate of decline for the period 1969-75.[12]

Illinois ranks in the top third among all states for births to women under 15 years of age, out of wedlock births, and mothers with three or more previous children.[10] For each of these indicators, the situation in Illinois has deteriorated more sharply than the national scene, as demonstrated in Table 2. The percent of Illinois births to unmarried mothers has ballooned from 6% in 1960 to more than 20% in 1979.

Among 56 cities of over 250,000 population, Chicago ranks among the worst 10 for proportion of mothers starting prenatal care in the first trimester, for births to women under age 18, and for births to women over age 34.[13] Chicago is among the lowest 20 of the 56 largest cities for births to women who have had less than 8 years of schooling.[10]

Although preconception and prenatal care services can reduce the chances of poor pregnancy outcomes among high risk groups, these women continue to have fewer prenatal visits than lower risk women. It is apparent that future efforts will need to address barriers to receipt of services by these women.[14]

Mortality: Neonatal and Birthweight-Specific

For those factors affecting survival rates among infants grouped by birthweight, specialized perinatal medical care, (which includes obstetrical management near and at delivery, as well as neonatal intensive care afterward) can reduce added health risks posed by low birthweight, sex, race and gestational age.

Analyses of improvements in neonatal and infant survival rates noted in both Illinois and nationally since 1960 demonstrate that improved outcomes are primarily due to higher survival rates among all birthweight categories under 2501gms for both whites and nonwhites and to a decreased incidence of low birthweight, primarily among whites.[1-4,15-17]

Intensive perinatal medical care has been responsible for most of the improvement in neonatal mortality since 1960 and has been responsible for a greater part of the overall reduction among nonwhites than among whites. It represents a second and very effective approach to improving perinatal outcomes.

Postneonatal Mortality

Although the prime focus of this discussion has been on the neonatal mortality component of infant mortality, the fact that postneonatal mortality is now also a major problem in Illinois must not be overlooked. The postneonatal mortality rate for Chicago residents is extremely high and has actually been increasing in recent years among both whites and nonwhites. The rate for Chicago residents is more than twice the postneonatal mortality rate for downstate residents, as demonstrated in Table 1. Similar differentials are noted for East St. Louis and certain other parts of the state.

The postneonatal mortality rate is related to environmental and social conditions, as well as the ability of the family to access primary health care services during the first year of life. Whereas low birthweight has been found to be the prime predictor of neonatal mortality, both low birthweight and low income status have been identified as strong predictors of postneonatal mortality.[14] Since it is related to family, social, cultural and economic conditions the postneonatal mortality rate will be especially resistant to reduction through health care intervention strategies alone. Accessibility and availability of primary medical care services, health education, and development of parenting skills prenatally and through the use of home visitors such as public health nurses, are important health care strategies. Each will be necessary to deal with

the rising postneonatal mortality rate in Chicago and certain other parts of the state.

Postneonatal follow-up and health supervision therefore represent a third public health strategy that can serve to improve survival rates for infants. ◂

Note to Readers

Methods to target one or more of these three strategies for implementation will be presented in the second part of this review of approaches to further reduce infant mortality in Illinois.

Laurilynn McGill, M.P.H., is an evaluation specialist, division of family health, Illinois Department of Public Health, Springfield. Ms. McGill is a former program coordinator for IDPH and research assistant for the Health Services Research Institute, University of Texas Health Science Center.

Bernard J. Turnock, M.D., is a deputy commissioner with the Chicago Department of Health. Board certified in preventive medicine and public health, Dr. Turnock was chief of the IDPH division of family health at this writing. Dr. Turnock formerly practiced pediatrics, and had served as assistant chief for the bureau of maternity services, New York City Department of Health.

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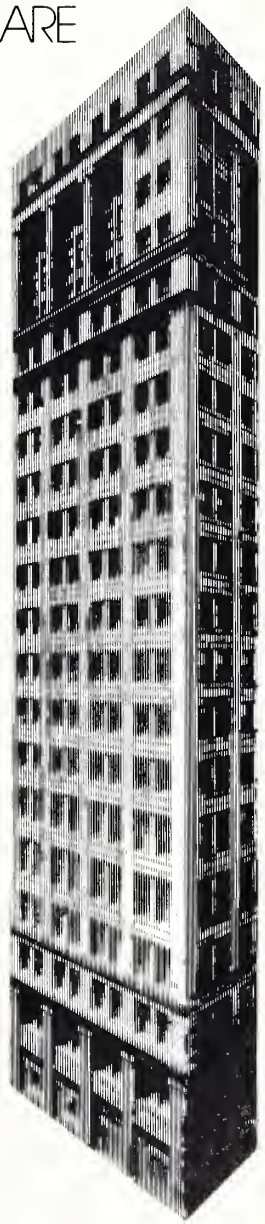
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Annual Meeting Summary 1983



Outgoing president Cyril C. Wiggishoff, M.D., (R) administers the oath of office to Robert P. Johnson, M.D., 1983-84 ISMS president.



Illinois Governor James R. Thompson addresses the house.

New Officers and Trustees

Highlights

Summary of Actions

Illinois State Medical Society
1983-1984 Officers and Board of Trustees

OFFICERS

PRESIDENT	Robert P. Johnson, M.D., 3000 Bennington Ave., Springfield, 62704
PRESIDENT-ELECT	Robert C. Hamilton, M.D., 711 W. North Avenue, Chicago 60610
1ST VICE-PRESIDENT	Ronald G. Welch, M.D., 333 S. Illinois, Belleville 62220
2ND VICE-PRESIDENT	Alfred J. Clementi, M.D., 675 W. Central Rd., Arlington Hgts. 60005
SECRETARY-TREASURER	Jere E. Freidheim, M.D., 3050 S. Wallace, Chicago 60616
CHAIRMAN, BOARD OF TRUSTEES	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946

HOUSE OF DELEGATES

SPEAKER	Julian W. Buser, M.D., 6600 W. Main, Belleville 62223
VICE-SPEAKER	Lawrence L. Hirsch, M.D., 2434 Grace, Chicago 60618

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	1985	Richard Blankshain, M.D., 715 Lake Street, Oak Park 60301
	1986	Audley F. Connor, Jr., M.D., 7531 S. Stony Island Ave., Chicago 60649
	1984	Morris T. Friedell, M.D., 7531 S. Stony Island Ave., Chicago 60649
	1984	Henrietta Herbolsheimer, M.D., 1700 E. 56th St., Chicago 60637
	1986	Harold L. Jensen, M.D., 3235 Vollmer Rd., Flossmoor, 60422
	1984	Arthur R. Peterson, M.D., 2740 W. Foster, Chicago 60625
	1986	Pedro A. Poma, M.D., 1200 Superior, Suite 402, Melrose Park 60160
	1984	Clifton L. Reeder, M.D., 516 Sheridan Rd., Wilmette 60091
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10TH DIST.	1984	Thomas P. Meirink, M.D., 8601 W. Main St., Belleville 62223
11TH DIST.	1986	Raymond Dieter, Jr., M.D., 454 Pennsylvania, Glen Ellyn 60137
12TH DIST.	1986	Raymond E. Hoffmann, M.D., 1030 Highview Ave., Rockford 61107
TRUSTEE-AT-LARGE	1984	Cyril C. Wiggishoff, M.D., 2800 N. Sheridan Rd., Suite 602, Chicago 60657

AMA Delegation Chairman, *Ex-Officio*	Howard C. Burkhead, M.D., 130 Dempster St., Evanston 60202
ISMIE Board of Governors Chairman, *Ex-Officio*	Fred Z. White, M.D., P.O. Box 279, 525 Sweetbriar, Chillicothe 61523

1983 ISMS Annual Meeting Highlights

An appearance by Gov. James R. Thompson highlighted the 1983 annual meeting of the Illinois State Medical Society House of Delegates. Speaking at the final session of the three-day meeting in April, the Governor called upon the state's medical leaders to join his fight for an increased state income tax and pledged to review Medicaid reimbursement rates if new tax revenues are generated.

Thompson visited the House as the physician-delegates were closing their business—business that included the presentation of reports by Society officials, the discussion of 40 policy resolutions and the election of new leadership.

In his remarks, the Governor complimented Society members on their contributions to Illinois residents and expressed dissatisfaction with physicians receiving late payment for the public aid cases they treat. Thompson commended physicians for their: free treatment of the indigent; service as "gatekeepers of health care for the poor"; endurance of government participation in health care delivery; service provided "efficiently, willingly and compassionately"; patience maintained while receiving late Medicaid reimbursements; work toward cost containment in the health care system; and cooperation with capitation programs.

The Governor assured the House that he was working to remedy the late payment situation. While requesting the Society's endorsement of the proposed tax increase, Thompson promised that if new revenues are received next year, reviewing the Medicaid payment schedule would be a top priority. Prior to the Governor's address, the Society's Board of Trustees had voted to support increased revenues for the health and educational needs of Illinois citizens.

"We Must Learn As Leaders": ISMS President

Addressing delegates with the words "Gentlemen, it's not business as usual," newly-installed ISMS President Dr. Robert P. Johnson advised physicians



to further educate themselves concerning health care cost matters.

"We must learn as leaders," Dr. Johnson said. "We must learn the alphabet of cost containment."

Dr. Johnson, a board-certified obstetrician-gynecologist in Springfield, listed the many acronyms related to medical cost control that physicians must learn to master. The list included: PPO (Preferred Provider Organization); EPO (Exclusive Provider Organization); PPP (Participating Physician Plan); and DRG (Diagnosis Related Groups).

The new president urged physicians to prepare for future changes in health care practice and to be ready to compete in the world those changes create. Dr. Johnson, a former first vice-president, also has served as speaker and vice-speaker of the House.

Communication, Cooperation Stressed



Dr. Tuttle reported that, during the past year, improved communication from the grassroots of the Society had made officers and trustees more responsive to membership needs. Dr. Tuttle also informed the House that the Society's financial situation was solvent and that "the affairs of the Society are in good order."

In self-described "valedictory" remarks, Dr. Cyril C. Wiggishoff stepped down as ISMS President with a message to the physician-delegates on the importance of communication.

Dr. Wiggishoff spoke of informing the public through the media and noted the necessity of maintaining clear communication within the Society as well. He told the delegates of his pleasure in

attending the functions of many county medical societies and noted the friendly relationship he had developed with Dr. Warren D. Tuttle, chairman of the ISMS Board of Trustees.

"We have a *fine* profession. We have a *fine* Society. We have a *strong* Society," Dr. Wiggishoff said in closing.

Echoing that note, Alexander R. Lerner, ISMS executive administrator, told the House: "The soundness of the Society's financial position and the staff's administrative expertise are especially important in coping with the challenges facing ISMS in the months and years ahead." Mr. Lerner cited as challenges how TEFRA regulations will affect hospital-based physicians, how the state's continuing fiscal problems will affect Medicaid reimbursement and how prospective payment systems will affect the delivery of health care.



Mr. Lerner assured the House that ISMS can meet these challenges head-on by using the "collective wisdom of the membership, the direction and policy determination of this House, the leadership of the Society's officers and Board of Trustees and the responsiveness and support of staff."

IMPAC Seeks Continued Support

Dr. Paul Mahon, chair of the Illinois State Medical Society Political Action Committee (IMPAC), reaffirmed the success of IMPAC activities and encouraged physicians to recruit their colleagues to join the committee.

Dr. Mahon noted that of 184 candidates supported by IMPAC in the recent November elections, 153 were elected. He continued that, considering the unusual circumstances surrounding the November election (the cut-back amendment, redistricting), IMPAC's success was particularly impressive.

"In many cases IMPAC support was the decisive factor in determining a positive outcome," Dr. Mahon said. He cited the example of an IMPAC-supported Republican candidate running for office in the Democratic stronghold of Chicago. "The IMPAC-supported candidate is now the one and only Republican representative out of 38 from Chicago," he said. Dr. Mahon added that, while IMPAC endorsed a Republican in this instance, the committee has maintained its non-partisan approach to political activity.

Financial Contributions Raised For Medical Students

Dr. Wiggishoff presented a check totaling $170,152.83 to Dr. Henry Russe, dean of Rush Medical College and chairman of the Council on Medical School Deans. The amount was contributed by physicians and ISMS auxilians in 1982 and was channeled through the American Medical Association-Education and Research Foundation. The funds are unrestricted grants made available to medical schools.

On the first night of the annual meeting, the ISMS/ISMSA-sponsored auction raised about $10,000 for the Financial Aid to Medical Students Fund in the ISMS Educational and Scientific Foundation.



The annual past presidents' dinner was held Thursday evening, April 21, at the Park Hyatt Hotel. Standing above (L-R) Willard C. Scrivner, M.D., Fredric D. Lake, M.D., David S. Fox, M.D., Edward W. Cannady, M.D., Joseph H. Skom, M.D., Jacob E. Reisch, M.D., P. John Seward, M.D., J.M. Ingalls, M.D., Newton DuPuy, M.D., and J. Ernest Breed, M.D. Seated (L-R) are Leo P.A. Sweeney, M.D., Herschel Browns, M.D., Fred Z. White, M.D., ISMS Past President and AMA President-Elect Frank J. Jirka, Jr., M.D., and special guest William Rial, M.D., AMA president.

ISMS Elects Officers, Trustees

Dr. Robert P. Johnson, Springfield, was inaugurated as ISMS president during the Society's April 24 House of Delegates session. He also was elected a delegate to the American Medical Association. A board certified obstetrician-gynecologist, Dr. Johnson has served as ISMS president-elect and first vice-president, as well as speaker and vice-speaker of the House. He succeeds Dr. Cyril C. Wiggishoff, Chicago.



AMA President-Elect Frank J. Jirka, Jr., M.D., addresses the House

Dr. Robert C. Hamilton, Chicago, was elected as ISMS president-elect. Dr. Hamilton, an ISMS trustee and past president of the Chicago Medical Society, also was elected an AMA delegate. He is a board certified orthopaedic surgeon.

Other officers elected were Drs. Ronald G. Welch, Belleville, first vice-president; Alfred J. Clementi, Arlington Heights, second vice-president; Jere E. Freidheim, Chicago, secretary-treasurer; Julian W. Buser, Belleville, speaker of the house and Lawrence L. Hirsch, Chicago, vice-speaker.

Third district trustees elected were Drs. James H. Andersen, Oak Brook; Audley F. Connor Jr., Chicago; Harold L. Jensen, Flossmoor; Pedro A. Poma, Melrose Park; and Harry A. Springer, Winnetka. Physicians elected to downstate trustee posts were Drs. Allan L. Goslin, Streator, 2nd district; Raymond A. Dieter Jr., Glen Ellyn, 11th district and Raymond E. Hoffmann, Rockford, 12th district.

Following the House meeting, the Board of Trustees re-elected Dr. Warren D. Tuttle, Harrisburg, chairman. Dr. Tuttle has served as ISMS board chairman since April, 1982 and also has served as chairman of the Board of Directors of Illinois State Medical Insurance Services, Inc. Due to vacancies created when incumbents were elected to other offices, the Board named Drs. Arthur R. Peterson, Chicago, and Clifton L. Reeder, Wilmette, as third district trustees.



Outgoing Speaker Clifton L. Reeder, M.D., (R) accepts congratulatory plaque and gavel from ISMS President Robert P. Johnson, M.D., at close of the final session of the House.

Elected AMA delegates were Drs. Clementi; Wiggishoff; Howard C. Burkhead, Evanston; Morgan M. Meyer, Lombard; Joseph H. Skom, Chicago; Arthur R. Traugott, Urbana and Michael L. Nieder, Chicago.

AMA alternate delegates elected were Drs. Freidheim; Goslin; Jensen; Poma; Tuttle; Welch; Randall T. Bellows, Chicago; James De Bord, Peoria; A. Beaumont Johnson, Elgin; and Fred Z. White, Chillicothe. Richard Terek, a medical student, also was named an alternate AMA delegate. ◀

Summary of Minutes 1983 Annual Meeting House of Delegates

The ISMS House of Delegates met at the Palmer House in Chicago, April 22-24, 1983, and took the following actions. The official minutes of the House are on file at the headquarters office of the Illinois State Medical Society.

Old Business

Substitute 16 (A-82)-Adopted
(BOT Report B)—Appointment of an Ad Hoc Committee of the House of Delegates to Adjust Downstate Trustee Districts' Boundaries
Introduced by Jerry Ramunis, M.D., for the Knox County Medical Society

Directed that Chapter VII of the ISMS Bylaws be amended as follows:

CHAPTER VII.
THE BOARD OF TRUSTEES

Section 1. Composition. The Board of Trustees shall consist of twenty-one trustees. . .

The trustee districts of the Illinois State Medical Society shall be:

Second District—Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford.

Eleventh District—DuPage County.

11 (A-81)—Not Adopted
(BOT Report C)—Freedom of Choice Health Insurance Legislation
Introduced by Robert R. Hartman, M.D., for the Board of Trustees

Defeated this resolution which called upon ISMS to offer and support legislation which would amend existing insurance laws in Illinois to provide consumers and those offering health insurance the opportunity to mutually determine the benefits covered (including physicians' services) in the health insurance offered and purchased.

7 (I-82)—Not Adopted
(BOT Report D)—*Modifying Mandatory Reporting Legislation*
Introduced by Samuel J. Schimel, M.D.

Defeated this resolution which called upon ISMS to make every effort to modify recently enacted legislation pertaining to mandatory reporting (Senate Bill 1614).

6 (I-82)—Not Adopted

(BOT Rep. E)—*Enactment of Legislation to Provide for Substituted Consent*

Introduced by Donald W. Aaronson, M.D.

Defeated this resolution which called upon ISMS to recommend that legislation be enacted providing that consent for furnishing medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.

18 (I-82)—Adopted as Amended

(BOT Rep. F)—*Strengthening Peer Review*

Introduced by Albert W. Ray, Jr., M.D., for the Will-Grundy County Medical Society

Directed that Chapter XII, Part 1 of the ISMS Bylaws be amended as follows:

CHAPTER XII PEER REVIEW

Part 1. Definitions. Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted by the county society where the physician holds membership or where the incident which served as the basis for the peer review complaint occurred. Ethical relations issues identified during deliberations of the county peer review committee, or where appropriate, the District Peer Review Committee may be referred to either the county or district ethical relations committee, as deemed appropriate by the county (district) committee.

Should an adverse decision be made against a physician by a county society where the reviewed practitioner does not hold membership, that decision will have the weight and effect of a decision made by his own county society.

Reference Committee On Constitution & Bylaws

1 (A-83)—Adopted
Amendment to Chapter IV., Section 4 of the ISMS Bylaws
Introduced by Robert P. Johnson, M.D., for the Board of Trustees

Amended Bylaws Chapter IV as follows:

CHAPTER IV
HOUSE OF DELEGATES

Section 4. Time and Place of Meetings.

A. Annual Meeting. The House of Delegates shall meet in an annual session and may meet in an interim session upon call of the Board of Trustees. The time and place of the annual meeting shall be as the House determines.

B. Interim Meeting. The Board of Trustees may schedule an interim session of the House of Delegates between annual meetings of the House if it determines that there is sufficient, relevant business. An interim meeting of the House should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. An interim meeting should be held in a district other than that of the preceding annual meeting.

7 (A-83)—Adopted as Amended
Restraints in School Buses
Introduced by James P. Campbell, M.D., for the DuPage County Medical Society

Directed that ISMS support state legislation requiring that all school buses be equipped with passenger safety restraints and other structural modifications to assure maximum impact safety.

14 (A-83)—Not Adopted
Committee Appointment
Introduced by John J. Taraska, M.D.

Defeated this resolution which called upon ISMS to direct that the President of the Illinois Society of Pathologists be a standing member of the Laboratory Services Committee.



IMPAC Chairman Paul F. Mahon, M.D., (R) accepts plaque from Dr. Wiggishoff.

16 (A-83)—Adopted as Amended
Proposed Increase in the Physician License Fee
Introduced by Alfred J. Clementi, M.D., Chairman Cook County Delegation

Directed that the Society: (1) Register its opposition to the proposed Physician License Fee increase until complete and full documentation of the needs and expenses of any disciplinary review is provided; and (2) Seek to have the license renewal period increased to three years on a staggered basis with the AMA Physician Recognition Award being accepted as equivalent to the State of Illinois CME requirements for licensure renewal.

19 (A-83)—Adopted as Amended
Resident Physician Membership
Introduced by David Whitney, M.D., for the Resident Physicians Section

Directed that the Society: (1) Encourage each ISMS regular member to recruit at least one resident physician member during the coming year; and (2) Assist the resident in the completion of the application process.

24 (A-83)—Referred to Board for Study
Conflicts Between ISMS Bylaws and the Judicial Panel HANDBOOK FOR THE CONDUCT OF DISCIPLINARY PROCEEDINGS
Introduced by Eugene P. Johnson, M.D.

Referred to the Board of Trustees for study a proposal to seek amendments to the bylaws to:

(1) Permit any person to file written charges against a physician with either the county medical society where the accused physician holds membership or in the county where the alleged incident occurred; and (2) Delete provisions which limit appeals to cases in which the accused has been found not guilty and therefore acquitted.

32 (A-83)—Adopted
Amendment to Chapter VIII of the Bylaws
Introduced by Robert P. Johnson, M.D., for the Board of Trustees

Directed that a provision be included in the bylaws stating that physicians elected to district committees shall serve a three-year term of office.

39 (A-83)—Adopted
Amendment to Chapter VII, Section 1 and Chapter IX, Section 8A, of the ISMS Bylaws
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Directed that Chapter VII and Chapter IX of the ISMS Bylaws be amended as follows:

CHAPTER VII.

THE BOARD OF TRUSTEES

Section 1. Composition. The Board of Trustees shall consist of twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange who shall sit as an ex-officio member having all privileges except the right to vote. Ten trustees shall be chosen from District 3 and one from each of the eleven districts.

CHAPTER IX. COMMITTEES

Section 8. Board of Trustees Committees. The Board of Trustees shall form the following committees within itself.

A. The Executive Committee shall consist of... The Chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote. The Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange who shall sit as an ex-officio member of the Executive Committee without vote.

Reports

Filed the following reports for information:

Committee on Constitution & Bylaws, Policy Committee, Judicial Panel and Peer Review Appeals Committee

Reference Committee A

Substitute 8 (A-83)—Adopted
Certificate of Need
Introduced by Morgan M. Meyer, M.D., for the DuPage County Medical Society

Directed that the Society: (1) Reaffirm its existing policy of urging the AMA to seek repeal of PL 93-641 and PL 96-79 or seek a legislative amendment in Congress or an Administrative exemption removing those portions of the Health Planning Act which impose penalties on the States not in compliance with Federal SHPDA designated criteria; and (2) Introduce a similar resolution to the AMA House of Delegates.

10 (A-83)—Adopted as Amended
Loss Prevention Program Attendance
Introduced by Peter A. Brusca, M.D., for the DuPage County Medical Society

Directed that the Society recommend that ISMIE: (1) Request that all physicians applying for liability insurance coverage attend an approved Loss Prevention program; and (2) Consider offering physicians a lowered liability insurance premium if they attend approved Loss Prevention programs.

Substitute 13 (A-83)—Adopted
Illinois Clean Indoor Air Act
Introduced by Mack Hollowell, M.D., for the Coles-Cumberland County Medical Society

Directed that ISMS reaffirm its 1979 policy statement concerning smoking and expand this policy further to support the spirit of Clean Indoor Air Act Legislation which prohibits smoking in certain designated areas used by the public.

15 (A-83)—Referred to Board for Study
Mandatory Levels of Liability Insurance
Introduced by Samuel J. Schimel, M.D.

Referred to the Board of Trustees for study a proposal that the Society: (1) Make every effort to stop hospitals from denying privileges to physicians who carry less than one million dollars in malpractice insurance; and (2) Sponsor legislation so that a physician cannot lose his staff privileges because he cannot afford to purchase insurance coverage for more than $100,000 per malpractice incident.

22 (A-83)—Referred to Board for Study
Anti-Trust Laws
Introduced by Erlo Roth, M.D., for the DuPage County Medical Society

Referred to the Board of Trustees for study a proposal that the House of Delegates of ISMS urge the AMA to join hands with other interested groups to seek appropriate modification of anti-trust laws so that enforcement of these laws does not restrict the learned professions from proper practice.

23 (A-83)—Referred to Board for Study
Federal Trade Commission
Introduced by Erlo Roth, M.D., for the DuPage County Medical Society

Referred to the Board of Trustees for study a proposal that the House of Delegates of the ISMS: (1) Endorse the activities of the AMA to reduce the self-asserted authority of the Federal Trade Commission over physicians and other members of the learned professions; and (2) Encourage the AMA to continue its efforts to win a victory in the next Congress to maintain physicians' rights to carry out patient advocacy activities.

Substitute 27 (A-83)—Adopted
Candidacy of John J. Ring, M.D. for the AMA Board of Trustees
Introduced by Peter L. Vinciguerra, M.D., for the Lake County Medical Society

Directed that: (1) The Society enthusiastically endorse the candidacy of John J. Ring, M.D., for the office of Trustee of the American Medical Association; and (2) Dr. John Ring's expertise on socio-economic issues be recognized and be widely communicated to the AMA membership and the AMA House of Delegates.

29 (A-83)—Adopted
Legal Definition of Death
Introduced by Jerry Ramunis, M.D.

Directed that the Society work with the Illinois State Legislature to establish legal definition of "Brain Death" in appropriate statutes of the State of Illinois.

37 (A-83)—Adopted
Pre-Trial Screening Panels
Introduced by Louis D. Tarsinos, M.D., for the Bureau County Medical Society and E. J. Fesco, M.D., for the LaSalle County Medical Society

Directed that the Society study the concept of pre-trial screening panels and report back to the House of Delegates at its next meeting concerning the advisability of pursuing legislation aimed at implementing such a system in Illinois.

Reports

Filed the following reports for information:

President, President-Elect, Chairman, Board of Trustees, Trustees, Executive Administrator, Secretary-Treasurer, AMA Delegation, Advisory Committee to the Auxiliary, Ad Hoc Committee on Hospital Medical Staffs, Illinois Society, American Association of Medical Assistants, Planning and Priorities Committee, Task Force on Membership/Marketing, Loss Prevention Education Committee, Governmental Affairs Council, Medical-Legal Council, Student Loan Fund Board, Committee on Insurance, Illinois State Medical Insurance Services, Inc., Department of Registration and Education

Reference Committee B

3 (A-83)—Adopted as Amended
Tax Credits or Deductions in Lieu of Reimbursement for Care of Public Aid Recipients
Introduced by Alfred Clementi, M.D., Chairman Cook County Delegation

Directed that the Society study and consider appropriate action to amend the Illinois statutes to allow physicians to receive a tax credit or tax deduction or deferred compensation for fees related to medical services provided Public Aid recipients.



Members of the ISMS 50 Year Club

4 (A-83)—Adopted
Cost Containment Activities vs. Quality Assurance Activities
Introduced by William P. Gibbons, M.D., for the DuPage County Medical Society

Directed that the Society and medical staffs clearly designate and distinguish in their bylaws and committee names, "cost containment" activities and "quality assurance" activities so that more clarity be brought to the developing conflicts between cost and quality.

5 (A-83)—Adopted as Amended
Emergency Medical Care at Large Functions
Introduced by Raymond A. Dieter, M.D., for the DuPage County Medical Society

Directed that the Society encourage the State of Illinois and the business community to provide an emergency medical kit and qualified individuals for the administration of appropriate medical care at functions where a very large number of individuals will be present.

12 (A-83)—Referred to Board for Study
Health Insurance Benefits Spelled Out
Introduced by Wallace Berkowitz, M.D., for the St. Clair County Medical Society

Referred to the Board of Trustees for study a proposal that ISMS recommend action to the Illinois General Assembly and the Illinois Insurance Department to require that health insurance subscribers be given specific accounting of the benefits contained in their insurance policies in the simple English language so that they know specifically what is covered by the policies and in what amount or percentages.

18 (A-83)—Not Adopted
Public Aid Cutbacks
Introduced by David Whitney, M.D., for the Resident Physicians Section

Defeated this resolution which called upon ISMS to: (1) Continue to study the effects of the newest IDPA cutbacks and their ramifications with respect to patient wellbeing, hospitals, and the individual practice of medicine by physicians; and (2) Make available results of this study at the 1983 Interim Meeting of the ISMS or, in the event of no 1983 Interim Meeting, such a study should be sent to all ISMS Delegates and Alternates by December, 1983.

26 (A-83)—Adopted as Amended
Implementation Date of Section 108 of TEFRA law of 1982
Introduced by John J. Taraska, M.D.

Directed the Society to: (1) Request that the HCFA and the Illinois Congressional Delegation delay and/or rescind implementation of the TEFRA regulations applicable to hospital-based physicians; and (2) Submit a similar resolution to the AMA at the next AMA meeting.

28 (A-83)—Adopted
Research Funds for Illinois
Introduced by Michael R. Treister, M.D.

Directed that the Society write to Illinois Congressmen and Senators requesting them to identify the sources of federal funding available for medical research, along with the amounts currently designated to Illinois research centers, and following such identification, to meet with ISMS to explore avenues by which a greater flow of these federal funds can be obtained for medical research conducted by Illinois scientists and institutions.

34 (A-83)—Referred to Board for Study
Good Samaritan Legislation for Medically Indigent Care Programs
Introduced by Raymond Hoffmann, M.D., for the Winnebago County Medical Society

Referred to the Board of Trustees for study a proposal that the Society introduce and/or support "Good Samaritan" legislation in the Illinois General Assembly which would provide immunity or other restriction from civil liability for physicians and other health care professionals who, in good faith, provide medical services through special programs for the medically indigent as long as standards of reasonable care within the local community are exercised.

Substitute 36 (A-83)—Adopted
Diagnostic Related Groups
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Directed that the Society: (1) Promote input by hospital medical staffs into the DRG process to ensure that quality of care is not compromised; (2) Pursue vigorously and expeditiously a program of education and assistance to the membership concerning DRGs; (3) Support the concept that the individual hospital medical staff's responsibility is to ensure appropriate quality of care standards for patients; and (4) Forward a similar resolution to the AMA.

38 (A-83)—Not Adopted
Diagnosis Related Groups
Introduced by Frank H. Chamberlin, M.D., for the Adams County Medical Society

Defeated this resolution which called upon ISMS and the AMA to vigorously bring to the attention of the general public the unpleasant consequences of DRG development if allowed to proceed unopposed.

40 (A-83)—Adopted
Prevention of Access to State of the Art Psychiatric Care by Inadequate HMO Coverage
Introduced by Earl N. Solon, M.D.

Directed that the Society undertake an in depth study of this matter which has potential detrimental impact on patients who are in need of such psychiatric services, to protect their health and ability to function in society.

Reports

Filed the following reports for information:
Council on Public Relations, Committee on Drugs and Therapeutics, Committee on Third Party Payment Processes, Committee on Health Planning, Health Data Committee, Council on Economics, Illinois Foundation for Medical Care

Reference Committee C

Substitute 2 (A-83) Adopted as Amended in Lieu of 2 (A-83) & 21 (A-83)
JCAH "Organized Staff" Standards
Introduced by Robert P. Johnson, M.D., for the Board of Trustees

Directed the Society to: (1) Define a "physician" as one who by education, training, experience, and licensing is able to practice medicine in all of its branches; (2) Encourage JCAH to require greater than a majority of fully licensed physician membership on the medical staff executive committees in acute care general hospitals; (3) Emphasize that JCAH standards clearly state the obligatory role of the medical staff in credentialing and in monitoring the quality of care in the hospital; (4) Encourage the development of the appropriate environment within the hospital so that both the medical staff and limited licensed practitioners may work together for the best interests of the patient; and (5) Incorporate these principles in a resolution to be introduced in the AMA House of Delegates at its June 1983 meeting.

6 (A-83)—Referred to Board for Study
Develop Three Ambulance Classifications in Illinois
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Referred to the Board of Trustees for study a proposal that the ISMS pursue changes in State of Illinois law to permit and encourage operation of ambulances which can be used for transporting patients without the need of highly trained personnel and expensive lifesaving equipment.

9 (A-83)—Not Adopted
Oppose Weakening of Medical Staff Responsibilities
Introduced by Garth D. Smith, M.D., for the DuPage County Medical Society

Defeated this resolution which called upon ISMS to: (1) Oppose bylaws revisions which weaken medical staff responsibilities for patient care and communicate this opposition to medical staff presidents through local medical societies; and (2) Develop and promulgate a model statement of medical staff purposes for the guidance of hospital medical staffs.

11 (A-83)—Not Adopted
Hospital Medical Staff Privileges
Introduced by William B. Frymark, M.D., for the DuPage County Medical Society

Defeated this resolution which called upon ISMS to: (1) Develop a comprehensive policy statement to guide hospital medical staffs in the granting and renewing of privileges; and (2) Submit a similar resolution to the AMA.

Substitute 17 (A-83)—Adopted as Amended
Chelation Therapy
Introduced by Joseph Perez, M.D., for the Winnebago County Medical Society

Directed the Society to: (1) Adopt the position, based on recommendations and reports from the American Heart Association, American College of Physicians, "Harvard Medical School Health Letter" and the "Medical Letter," that chelation therapy for atherosclerosis is an experimental procedure without proven efficacy; and (2) Submit a resolution to the AMA asking that chelation therapy for atherosclerosis be studied and a report prepared concerning its efficacy.

20 (A-83—Referred to RPS & MSS for Study
Chronic Care Patients
Introduced by David Whitney, M.D., for the Resident Physicians Section

Referred to the Resident Physician and Medical Student Sections a proposal that the ISMS encourage medical school curricula and residency training programs to address the issues of utilization of community resources, and the strategies for dealing with the long-term medical, rehabilitation, and social needs of chronic care patients.

Substitute 25 (A-83)—Adopted
The Rape Victim's Option to Have Access to the Assistance of a Rape Victim Advocate
Introduced by Malcolm Major, for the Medical Student Section

Directed that the Society: (1) Support the option of a rape victim to have the continuous presence, if available, of a rape victim counselor while receiving medical care if the victim so desires and consents; (2) Inform physicians through the *Illinois Medical Journal* on the function and efficacy of rape victim services; (3) Encourage rape crisis centers to continue working with local police officials in helping rape victims; and (4) Introduce this resolution to the AMA at its next annual meeting.

30 (A-83)—Adopted as Amended
The Use of Animals in Research and Education
Introduced by Malcolm Major, for the Medical Student Section

Directed that the Society endorse the position that research and medical education which involves the use of animals is necessary to enhance the medical care of the public.

31 (A-83)—Adopted as Amended
Hepatitis B Vaccine
Introduced by Malcolm Major, for the Medical Student Section

Directed that the Society: (1) Endorse the concept that housestaff and medical students often participate in high risk situations for which the Hepatitis B vaccine would be efficacious; and (2) Encourage medical schools and hospitals, at their prerogative, to provide the Hepatitis B vaccine to medical students as they may to other health care personnel in similar high risk situations.

35 (A-83)—Referred to Board for Study
Free Standing Emergency Centers (FSEC)
Introduced by C. Larkin Flanagan, M.D.

Referred to the Board of Trustees for study a proposal that ISMS: (1) Undertake to inform the public regarding the services offered in FSECs; (2) Foster a closer working relationship with the leadership of FSECs in order to clarify the quality of care issues; and (3) Continue to bring to the attention of the AMA House of Delegates and its councils the need for careful monitoring of FSECs, their advertising, their capabilities and their quality.

Reports

Filed the following reports for information:

Council on Education and Manpower, Council on Medical Services, Council on Mental Health, Task Force on Financial Aid to Medical Students, Committee on Accreditation, Publications Committee, Medical Student Section, Resident Physicians Section, Educational and Scientific Foundation, Illinois Council on Continuing Medical Education (ICCME), Illinois Department of Public Health, Illinois Department of Children and Family Services and Division of Rehabilitation Services

Memorial Resolutions

The House also adopted memorial resolutions in memory of Drs. John P. Harrod, Jr., Chicago, and Harlan A. English, Danville, and expressed its profound loss and condolences to their families.

President's Installation

Dr. Robert P. Johnson, Springfield, was installed as ISMS president, succeeding Dr. Cyril C. Wiggishoff, Chicago.

Elect Officers, Trustees, AMA Delegates

Election of Officers

At the concluding session of the House, 1983-84 officers were elected unanimously. They are: Robert C. Hamilton, M.D., Chicago, president-elect; Ronald G. Welch, M.D., Belleville, 1st vice president; Alfred J. Clementi, M.D., Arlington Heights, 2nd vice president; Jere E. Freidheim, M.D., Chicago, secretary-treasurer; Julian W. Buser, M.D., Belleville, speaker of the house and Lawrence L. Hirsch, M.D., Chicago, vice speaker of the house.

Election of Trustees

Elected trustees were: James H. Andersen, M.D., Audley F. Connor, Jr., M.D., Allan L. Goslin, M.D., Harold L. Jensen, M.D., Pedro A. Poma, M.D. and Harry A. Springer, M.D., third district; Raymond A. Dieter, Jr., M.D., eleventh district; and Raymond E. Hoffmann, M.D., twelfth district.

Judicial Panel

Frank B. Norbury, M.D., Jacksonville, was elected to serve a five year term on the ISMS Judicial Panel.

Illinois AMA Delegates

The House of Delegates elected AMA delegates and alternates to serve January 1, 1984 through December 31, 1985. Elected delegates were Howard C. Burkhead, M.D., Alfred J. Clementi, M.D., Robert C. Hamilton, M.D., Robert P. Johnson, M.D., Morgan M. Meyer, M.D., Joseph H. Skom, M.D., Arthur R. Traugott, M.D. and Cyril C. Wiggishoff, M.D. Alternate delegates elected were Randall Bellows, M.D., James R. DeBord, M.D., Jere E. Freidheim, M.D., Allan L. Goslin, M.D., Harold L. Jensen, M.D., Pedro A. Poma, M.D. and Warren D. Tuttle, M.D.

Additional Delegate & Alternate

The House of Delegates elected Michael Nieder, M.D., Chicago, as the 17th delegate to take office immediately and serve until December 31, 1984. Harold L. Jensen, M.D., was appointed to serve Dr. Nieder's unexpired term which runs through 1983. Richard Terek, student member, Chicago, was elected the 17th alternate delegate to take office immediately and serve until December 31, 1984.

1984 Dues

The Secretary-Treasurer announced that the per capita dues for 1984 were set at $253.

Attendance

The Credentials Committee recorded attendance of the 1983 House of Delegates as follows:

	First Session	Second Session	Third Session
Officers & Trustees	25	25	23
Speaker & Vice Speaker	2	2	2
Delegates:			
District 1	8	9	6
District 2	3	3	1
District 3	96	96	91
District 4	8	10	11
District 5	7	7	4
District 6	4	5	2
District 7	2	2	3
District 8	9	9	10
District 9	6	5	4
District 10	6	6	4
District 11	14	15	14
District 12	8	9	8
Intern/ Resident	0	1	0
Student	0	1	1
TOTAL	198	205	184

IMPAC

Illinois State Medical Society
Political Action Committee
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

NONPARTISAN

"No man's life, liberty or property is safe while the legislature is in session."

Anonymous

Help us to help you.

JOIN IMPAC

Contributions are not limited to the suggested amount Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon t amounts of or failure to make pac contributions Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5 (Federal Regulatic require this notice) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 Sou Spring Street, Springfield, Illinois, 62704 Voluntary membership contributions support political action committee membership in IMPAC for candidates for put office in Illinois and candidates for federal office elsewhere through AMPAC.

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Viewbox

(Continued from page 400)

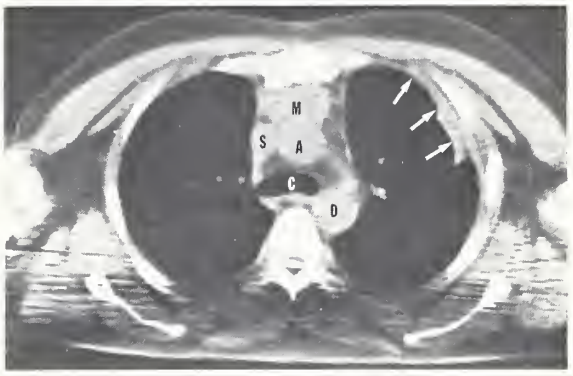


Figure 2
Large anterior mediastinal mass (M) anterior to the ascending aorta (A). The fat plane between the mass and the ascending aorta is obliterated, suggesting invasion of this structure. Extension into the pleural cavity on the left is seen (arrows). Superior vena cava (S), descending aorta (D), carina (C).

ANSWER: (d) Thymoma
(c) Computed tomography

Lymphoma and teratoma are certainly considerations in this patient. However, the clue here is the patient's diplopia. Myasthenia gravis may present with only eye findings, such as ptosis or diplopia. In any patient with myasthenia and a mediastinal mass, thymoma must be strongly suspected. Although neuropathy may be associated with sarcoidosis, hilar adenopathy is seldom unilateral.

A CT scan of the chest would be the preferred imaging modality. It is far superior to conventional tomography in defining mediastinal abnormalities, and can provide information on anatomic localization, as well as displacement or invasion of mediastinal structures. It can differentiate vascular, fatty and solid lesions. Mediastinal lymphadenopathy can be detected. Abnormal contour of the mediastinum is seen with conventional tomography, but resolution of separate mediastinal structures is poor.

Many inflammatory and neoplastic diseases are associated with gallium uptake, but in an area of known abnormality a gallium scan does not provide precise anatomic localization. In certain diseases, such as lymphoma or infection, it may be useful in searching for other sites of involvement.

Although an esophagram may be helpful, it does not provide nearly as much information as CT if the esophagus is not the primary site of disease.

An angiogram would not be appropriate as the next test in this patient as there is little evidence to suggest a primary vascular process, and in addition, CT can reliably identify vessels and vascular structures.

A CT scan of the chest was performed and showed a large mass in the anterior mediastinum in the region of the thymus (Fig. 2). Invasion of neighboring structures and pleura was evident. At surgery, a large thymoma was found which was firmly attached to the base of the great vessels and extended into the left pleural space. This extension accounted for the density over the left mid-lung on the original chest radiograph.

CT Detection of Thymic Enlargement

Computed tomography is the imaging method of choice following chest radiographs when thymic disease is suspected. Tumors which are not visible on plain radiographs and tomograms can be identified by CT. Abnormalities of thymic size and configuration, as well as definition of internal structure (solid versus cystic, calcium or fat content) can be defined, and gross invasion of adjacent mediastinal structures and intrathoracic metastases can be detected.[1,2]

Anatomy

The thymus gland is derived from the endoderm of the third and occasionally fourth pharyngeal pouches. It descends into the anterior superior mediastinum in early gestation. Posteriorly, it is molded over the trachea, superior vena cava and left brachiocephalic vein, aortic arch and its branches, and the superior pericardium. The sternum and lungs lie anteriorly and laterally. The thymus usually extends from a level just above the manubrium to the superior pericardium.

The two thymic lobes are surrounded by a fibrous capsule. Mesenchymal septa divide each lobe into multiple lobules, each containing an outer cortex which is rich in lymphocytes and an inner medulla primarily composed of thymic epithelial cells and Hassall's corpuscles.[3]

With failure of embryonic descent, ectopic thy-

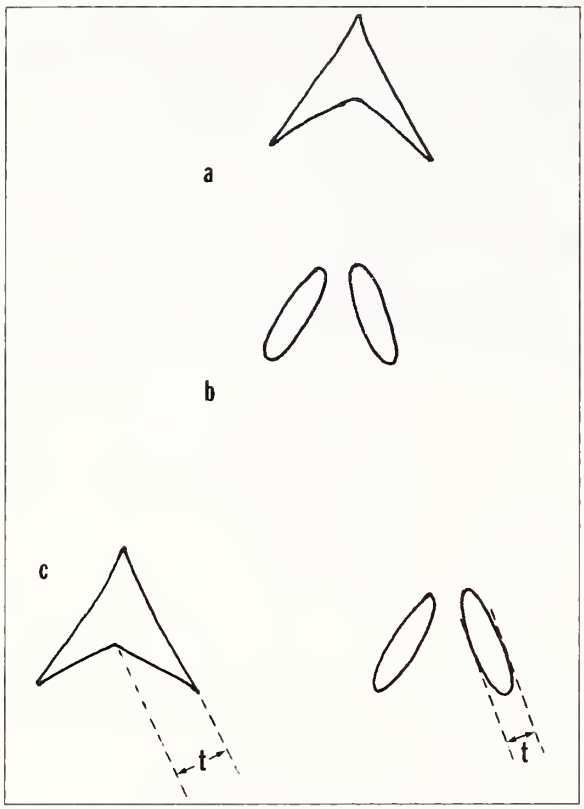


Figure 3
Configuration of the normal thymus on CT modified from Baron, et al.[2] (a) The "arrowhead" configuration. (b) Two separate ovoid lobes. (c) Method for determining thymus lobe thickness (t). Baron et al[2] found this measurement to be a maximum of 1.3 cm in subjects over 20.

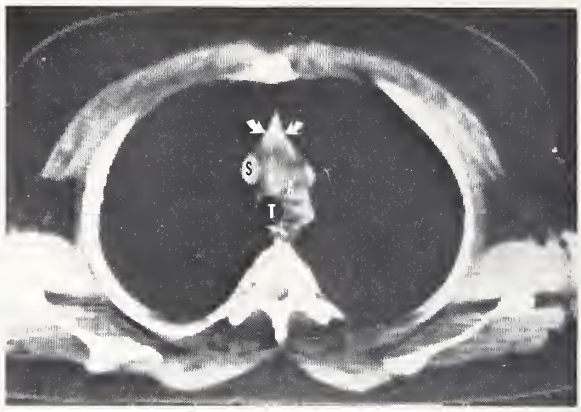


Figure 4
Normal thymus in a 16 year old male (curved arrows). Arrowhead configuration lying anterior to the aortic arch (A). The superior vena cava (S) and trachea (T) are also seen.

mic tissue has been reported in the neck as high as the base of the mandible. Ectopic tissue in the posterior mediastinum behind the superior vena cava has been reported and is not explained by embryonic development.[4]

In proportion to body weight, the thymus is largest at birth (mean weight 22gm).[3] The largest absolute size is at puberty (mean weight 34gm),[3] when it averages 6-8cm in length and 1-2cm in thickness,[5] and thereafter progressive involution and fatty replacement occurs. At age 60 the thymus weighs one-half what it did at age 19.[3]

Anatomy on CT

The appearance of the normal thymus on CT has been described.[2,6] It usually appears either triangular, with one apex of the triangle directed anteriorly (Fig. 3A) or has two separate ovoid lobes with the long axis of each pointing anteriorly and medially (Fig. 3B). The former appearance has been referred to as the "arrow head" configuration (Fig. 4). It appears larger and fuller in the mediastinum in young individuals.

In a study of 154 patients, Baron and associates were able to identify the normal thymus in 100% of patients under 30 years old, in 73% of those 30-49 years old, but in only 17% of those older than 49 years.[2] In all cases in which the thymus was visualized, it was located in the anterior mediastinum between the level of the left bronchiocephalic vein superiorly to the level of the base of the great vessels inferiorly. In their series, the maximum thickness was 1.3 cm in patients over 20 years old (Fig. 2C). The CT attenuation measurements (density) of the thymus tended to decrease with aging. In patients under 19 years old, the thymus measured isodense or higher with respect to the soft tissue of the chest wall, while patients over the age of 40 had attenuation measurements approaching those of fat (Fig. 5).

Thymic Masses

Thymic enlargement may be due to infection, hyperplasia, thymic cyst, or neoplasm (Table 1).

Thymic abscess is extremely rare,[3] and is usually associated with septicemia. Acute thymitis may occur with influenza, measles, miliary tuberculosis, infectious mononucleosis, and brucellosis.[3]

Thymic hyperplasia is a relatively frequent thymic abnormality. Hyperplasia may be associated with myasthenia gravis or with endocrine abnormalities, such as Grave's disease, Addison's disease, acromegaly, and congenital pituitary absence.[3] A normal appearance of the thymus on CT does not

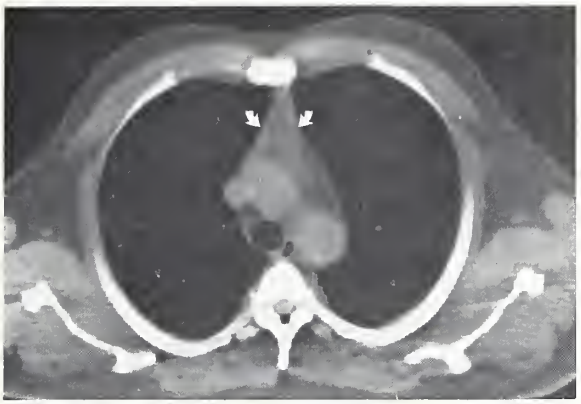


Figure 5
Normal thymus largely replaced by mediastinal fat in a 54 year old male. Attenuation measurements were those of fat density.

Table 1
Causes of Thymic Enlargement

Hyperplasia
Infection
"Thymitis," influenza, measles, tuberculosis, infectious mononucleosis, brucella
Abscess
Cysts
Simple cysts
Teratoma (cystic or solid)
Solid Tumors
Thymoma—invasive or non-invasive
Thymolipoma
Hodgkin's Disease
Germ Cell Tumors—teratoma (cystic or solid), embryonal cell, seminoma
Carcinoid
Secondary Involvement
Invasion
Metastases

exclude hyperplasia. The thymus may appear diffusely enlarged on CT but tends to maintain a normal configuration. Rarely, a focal mass is seen,[2] and in this situation CT cannot differentiate between thymic hyperplasia and thymoma.

Thymic cysts may be congenital, inflammatory, or neoplastic. They are usually asymptomatic. Their CT appearance is that of a well demarcated round or ovoid mass with a thin wall and a homogenous center of near water density (Fig. 6).

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC, National Academy of Sciences, 1980, p. 13.

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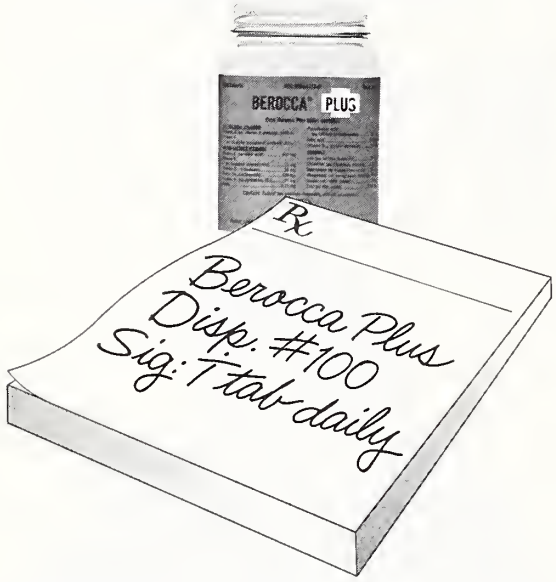
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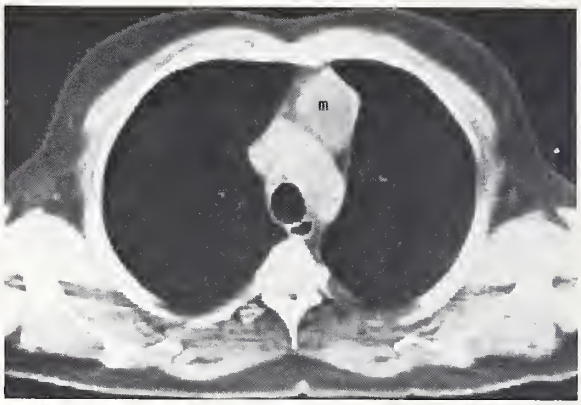


Figure 6
A large mass (m) in the thymic region with attenuation values measuring those of water and no enhancement following contrast administration. At surgery this proved to be a thymic cyst.

Table 2
Syndromes Associated with Thymoma

Myasthenia Gravis
Cushing's Syndrome
Hypogammaglobulinemia
Hypoplastic Anemia
Pure Red Cell Aplasia
Graves Disease
Multiple Endocrine Neoplasia
Polymyositis and Myocarditis
Systemic Lupus Erythematosis
Pemphigus
Sjogren's Syndrome
Rheumatoid Arthritis

No enhancement is seen following intravenous contrast enhancement. The cyst wall may contain rim-like areas of calcification.[8] Most thymic cysts are probably congenital in origin. Rastegar, *et al,* suggest that surgery is not indicated when the classic radiologic picture of thymic cyst is seen in an asymptomatic individual.[8] However, they also warn that mediastinal teratomas may occasionally have an identical appearance.

Multiple small thymic cysts may be present in infants with congenital syphilis.[3] Hemorrhage into a thymic cyst has been reported as a cause of acute symptomatic mediastinal widening in children with aplastic anemia.[9] A recent report documents the development of thymic cysts following radiation therapy for Hodgkin's disease.[10] The authors postulate that this results from successful radiation of a thymus previously involved with Hodgkin's disease.

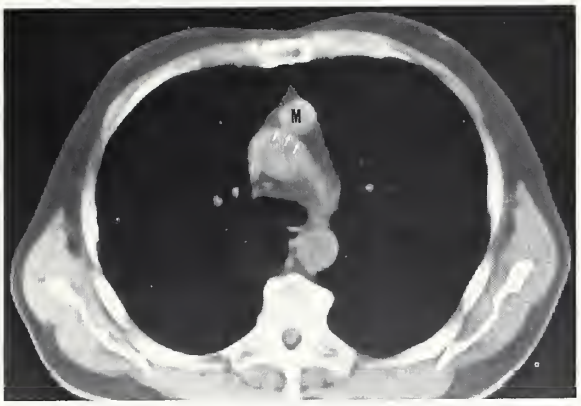


Figure 7
A thymic mass (m) in a 32 year old man with myasthenia gravis and a normal chest x-ray. A well encapsulated, non-invasive thymoma was found at surgery. Integrity of the fat plane between the aortic arch and the mass (arrows) would favor a non-invasive thymoma. (Compare with absence of fat plane seen in Fig. 2).

Thymoma is the most common thymic tumor.[3] It is uncommon before age 30, with a peak incidence in the fifth through seventh decades.[11,12] Thymomas are histologically classified as lymphocytic, epithelial, or mixed lymphoepithelial, depending on the predominant cell type. There is no consistent relationship between their histologic appearance and subsequent clinical behavior.[11,12] Tumors appearing histologically malignant may have a benign clinical course, and benign appearing tumors may metastasize or infiltrate into surrounding structures. Thus, thymomas are usually classified as non-invasive versus invasive, with the former being contained by a dense connective tissue capsule and the latter showing absence of a capsule or invasion into mediastinal fat or adjacent mediastinal structures. Distant metastases also indicate aggressiveness, and when present most commonly involve the pleura, and occasionally the bones. The percentage of thymomas showing invasive characteristics ranges from 7 to 67%, with most series reporting 25 to 35%.[11]

Numerous syndromes have been associated with thymomas (Table 2), the most frequent being myasthenia gravis. The incidence of myasthenia in patients with thymomas is largely dependent on the population being studied, but the overall incidence has been estimated at 20 to 30%.[11,13] Conversely, 8 to 15% of patients with myasthenia harbor a thymoma.[14,15] Occasionally, removal of a thymoma will antedate the clinical development of myasthenia by up to several years.[11] On the whole, thymomas are no more aggressive in patients with myasthenia than in patients without myasthenia.[16]

CT may show a focal thymic mass or diffuse enlargement, often with the loss of the characteristic thymic configuration. As in the case presented initially, invasion into adjacent organs or fat planes, or pleural metastases may be present, thus demonstrating invasive characteristics.

Recently, routine CT scanning of the mediastinum has been recommended in patients with myasthenia gravis, since up to 40% of patients with thymoma will have a normal chest radiograph[1] (Fig. 7).

The prognosis of non-invasive thymoma is excellent, with a recurrence rate of less than 6% on long term follow up.[11,13,16] Patients with invasive thymomas have a more guarded prognosis, with an expected 5 year survival of 23 to 50%[7] and may succumb to infectious or respiratory complications. They are treated with radiotherapy following surgery.

Thymolipomas are rare benign hamartomatous tumors, largely composed of adipose tissue.[3] These may occasionally attain huge sizes, up to 6000 gms and can simulate cardiomegaly.

Hodgkins disease may involve the thymus and has a good prognosis if localized.[18] Thymoma rarely involves mediastinal lymph nodes, and the CT finding of thymic tumor accompanied by mediastinal lymph nodes should raise a strong suspicion for Hodgkins disease.

Benign teratomas are often cystic and CT may show that they contain fat, calcium, or both, thus providing a clue to their nature. The mediastinum is the second most common site for involvement by teratoma, the most common site being the gonads.[21]

Malignant germ cell tumors of the thymus include malignant teratoma, embryonal carcinoma, and seminoma. They generally have a poor prognosis, though patients with seminomas occasionally do well following radical surgery and radiotherapy.[21]

Primary carcinoid tumors of the thymus are rare, and are not associated with the classic carcinoid syndrome.[19] One-third of these will be associated with Cushing's syndrome because of ACTH secretion. They may be seen in patients having the multiple endocrine neoplasia syndrome, Type I. At least 30% of thymic carcinoids are malignant on the basis of invasion and/or metastases.[19]

The thymus may be secondarily involved with carcinoma by invasion or metastases. Tumors of the lung, breast, and thyroid are the most frequent to involve the thymus. ◀

References

1. A complete list of references for this month's Viewbox may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

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Abstracts of Board Actions

(Continued from page 391)

FINANCES

Acting on reports of the Executive and Finance Committees, the Board:

- Accepted the December 31, 1982 audited financial statements and schedules—prepared by Ernst & Whinney—of ISMS, Illinois State Medical Benevolent Fund, Inc., ISMS Educational and Scientific Foundation and the Illinois Council on Continuing Medical Education.
- Authorized purchase of a Publishers Liability Insurance policy for the Society's publications, with limits of $5,000,000 and a deductible of $25,000, at an annual premium of $3,424. Cost of policy will be funded from undesignated funds.
- Authorized a $2,500 contribution from undesignated funds to the American Medical Association for joint expenses related to the installation of Dr. Frank Jirka, Jr., as AMA president.

HOSPITAL MEDICAL STAFFS

Acting on recommendations of the Ad Hoc Committee on Hospital Medical Staffs, the Board voted to:

- Urge county medical societies to form standing committees including hospital medical staff representatives and that those county committee representatives, if possible, include representatives of each hospital to the AMA Section on Hospital Medical Staffs.
- Consider holding a leadership conference in place of or in addition to the Interim Meeting, and invite hospital medical staff presidents and others interested in the issues facing hospital medical staffs.

LICENSE FEES

After discussion of an R & E proposal to raise license fees to $150 every two years, the Board approved a position that licensure be for a 3 year rotating period and the amount of the fee be no more than $75 for three years.

DRUGS AND THERAPEUTICS

The Board approved the following drug product for inclusion in the IDPA Drug Manual: Infalyte (Sodium 50mEq., Potassium 20mEq., Chloride 40mEq., Bicarbonate 30mEq. and Glucose 111mEq. per liter of solution 24 packets).

The Board also recommended that the following drugs not be included in the Drug Manual: Zorprin—800mg. tablet; Norpramin—10mg. tablet; Halcion—.25mg. and 0.5mg. tablets; Aeroseb-DEX 0.01%—7.10/58g.; Aeroseb-HC—0.5%—6.36/58g.

The Board further recommended that the following drugs be removed from the Drug Manual: Disalcid (500mg. and 750mg.); Trilisate (only 500mg. and 750mg.); Magnesium Salicylate (only 600mg.); Pedialyte; Hydrocortisone Cream and Ointment 1.0% in the 30g. size; all Hydrocortisone 0.25% and 0.5% products; Vitamin B-6 Injections; Vitamin B-6 10mg. Tablets; Asendin; Vivactil; Lytren; and all liver extract injections.

The Board further recommended that Restoril—only for recipients in long term care facilities; Cortifoam and Proctofoam-HC be restored in the IDPA Drug Manual.

The Board reviewed an appeal concerning Ludiomil, a product previously not recommended for inclusion in the IDPA Drug Manual, and recommended that the IDPA include Ludiomil (Maprotiline) in the strengths of 25mg., 50mg. and 75mg. in the Drug Manual.

OTHER ACTIONS

In addressing various other issues, the Board:

- Directed that ISMS support state revenue increases necessary to meet essential and basic health and educational needs.
- Approved for introduction in the House of Delegates a resolution that would amend the bylaws to provide for a three-year term of office for members of district committees.
- Directed that the ISMS leadership urge the Governor and IDPA not to implement budget cuts in the obstetrical care area.
- Referred the concept of an emeritus status license to the Executive Committee for study and report back to the Board.
- Authorized introduction of a resolution to amend the bylaws to provide that the Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member of the Board of Trustees and the ISMS Executive Committee, having all privileges except the right to vote.
- Approved a telephone membership retention project for Friday, June 3, 1983, in which trustees would call all 1982 ISMS members who did not renew their membership in 1983.
- Approved a membership panel to determine why members do and do not join, made up of foreign medical graduates and women physicians, and including non-members.
- Directed that all Third Party Payors be contacted in regard to psychologists being included as providers of medical service and ask them to remove psychologists from the list of providers of medical psychotherapy services, subject to written review and approval by legal counsel.
- Recommended that IDPA adopt the Third Party Payment Processes Committee's changes in the Periodicity Screening Schedule for Medichek.
- Considered an ongoing dialog between leadership and staff of ISMS and the Illinois Hospital Association as a priority activity.
- Referred back to the Council on Mental Health and Addiction for further study and report a recommendation that ISMS oppose further reduction in IDMH/DD's operating budget.
- Approved in concept a proposal that Category 1-a credit be offered for membership and participation in the ISMIS Physician Review and Evaluation Panels and the Physician Review Committees, and directed that a meeting between ISMS and the Department of Registration and Education be arranged to discuss such a proposal for amending the current mandatory CME regulations.
- Referred the Council on Education and Manpower's report on the impact of reduced funding of Illinois primary care residencies back to the Council for more data on residency status and physician needs in Illinois.
- Discussed positions recommended by the Governmental Affairs Council, on a list of bills pending in the General Assembly.
- Directed that the Ad Hoc Committee on Resolution 37 (A-81) continue to function to meet the intent of Resolution 37 (A-81) in developing model staff by-laws.
- Supported voluntary rather than mandatory certification of athletic coaches.
- Formulated an ad hoc committee—to be appointed by the chairman—to study the issue of Physician Review Organizations.

PROGRAMS

The Board authorized the following program activities:

- Development of a sports medicine program for the 1984 Midwest Clinical Conference.
- Co-sponsorship of the AMA September 8-10, 1983, national conference titled, Impact of Lifestyles on Child and Adolescent Health.
- Co-sponsorship of the AMA Conference on Child Abuse to be held in April, 1984, and appointment of Dr. Jere Freidheim, Chicago, as ISMS representative at a planning meeting May 9, 1983.

ELECTIONS, APPOINTMENTS AND NOMINATIONS

Various elections, nominations and appointments were approved or ratified by the Board. These were as follows:

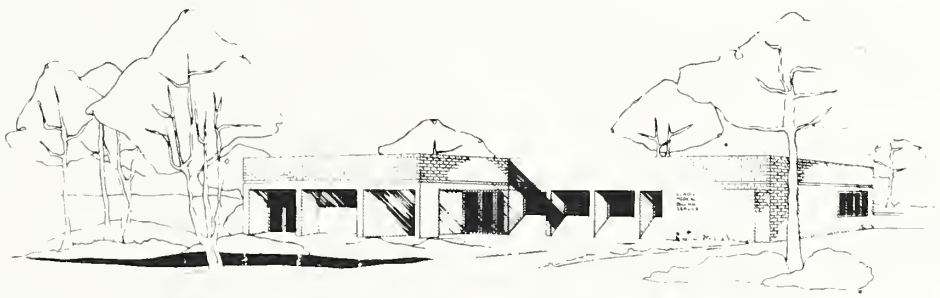
- Re-elected Dr. Warren D. Tuttle, Harrisburg, as chairman.
- Elected Drs. Arthur R. Peterson, Chicago, and Clifton L. Reeder, Wilmette, for one year terms as Trustees from the Third District to fill positions declared vacant when the incumbents were elected to other office.
- Appointed Dr. Alfred J. Kiessel as Finance Committee chairman, and Dr. Richard H. Blankshain, as Policy Committee chairman.
- Nominated Drs. Phillip Boren, Alfred Clementi, Robert Hamilton, Jerry Ingalls, Clifton Reeder, and Warren Tuttle to the ISMIS Board of Directors.
- Appointed Alexander R. Lerner as proxy for the shareholder, Illinois State Medical Society, at the annual meeting of ISMIS, May 4, 1983, to cast the vote for Directors of ISMIS.
- Nominated Drs. Joan Cummings, Hines; Ron W. Lee, Chicago; and Brent Scott, Oak Brook, to serve on the IDPH Emergency Medical Services Advisory Council.
- Nominated Dr. W. David Steed, Oak Park, for an additional term on the Governor's Citizen's Advisory Council on Alcoholism.
- Appointed Dr. Robert Johnson, Springfield, to the AMA's Advisory Council of the Health Policy Agenda for the American People.
- Endorsed Dr. John W. Pollard, Champaign—who has been nominated by the American Group Practice Association—to the Advisory Group to Study Changes in Medicare Physician Reimbursement.
- Accepted the election of Dr. Francis H. Straus II, to the ICCME Board as representative of the University of Chicago Pritzker School of Medicine. ◀

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JULY

Emergency Medicine

Old Dilemmas in the Emergency Room
For: Emergency Physicians. Lectures/workshops, July 21-22, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $175. **Reg. limit:** none. **Credit:** Category 1, 13 hours; AOA, 13 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Emergency Medicine

Managing the Unmanageable
For: MD's. Conference, July 23, 24, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 10 hours; AAFP Elective, 10 hours; AOA, 10 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Dermatology

Practical Office Dermatology
For: Internists, Pediatricians, FP's, GP's. Lecture, July 12-16, Chicago. **Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $350. **Reg. limit:** 85 hours. **Credit:** Category 1, 37 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Gynecology

Office Gynecology
For: Internists, FP's, GP's. Lecture, July 12-14, Chicago. **Speaker:** M. LeRoy Sprong, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $250. **Reg. limit:** 85. **Credit:** Category 1, 21 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Medicine

Environmental Medicine
For: Internists, FP's, GP's, Occupational Medicine. Lecture, July 19-23, Chicago. **Speakers:** Stephen Greenberg, PhD; Emerson Day, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $325. **Reg. limit:** 85. **Credit:** Category 1, 30 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Medicine

Specialty Review in Internal Medicine/Certifying
For: Internists. Lecture, July 25-Aug. 1, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 600. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Neurology

Tardive Dyskinesia: An Overview and Update
For: Psychiatrists, Neurologists. Lecture, July 14-15, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago. **Reg. deadline:** 6/30. **Fee:** yes. **Credit:** Category 1, 6 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Oncology

Urologic Oncology
For: Urologists, Oncologists, Pathologists. Lecture, July 11-14, Chicago. **Speaker:** Thomas John, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $325. **Reg. limit:** 90. **Credit:** Category 1, 28 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathology

Liver & GI Clinico-Pathologic Conference
For: Pathologists. Lecture, July 26, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312-578-3215.

Pediatrics

Specialty Review in Pediatrics
For: Pediatricians. Lecture, July 19-24, Chicago. **Speaker:** Ira DuBrow, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 300. **Credit:** Category 1, 63 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Urology

Summer Clinical Series
For: Urologists. Course, July 30-31, Palmer House, Chicago. **Sponsor:** American Urological Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 7/30. **Fee:** Yes. **Reg. limit:** 200. **Credit:** Category 1. **Contact:** Alice Henderson. **Phone:** 713-790-6070.

AUGUST

Emergency Medicine

Specialty Review in Emergency Medicine
For: ER Physicians. Lecture, August 1-6, Chicago. **Speaker:** James Mathews, IV, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $425. **Credit:** Category 1, 47 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Medicine

Specialty Review in Internal Medicine/Certifying
For: Internists, Medical Subspecialists. Lecture, August 7-13, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pediatrics

Specialty Review in Neonatology/Perinatology
For: Pediatricians, Obstetricians. Lecture, August 29-Sept. 2, Chicago. **Speaker:** Dharmapuri Vidyasagar, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 50 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Specialty Review in General Surgery, Part II
For: General & Specializing Surgeons. Lecture, August 15-26, Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $600. **Credit:** Category 1, 100 hours. **Contact:** Robert Baker. **Phone:** 312/733-2800.

Surgery

Fiberoptic Colonoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, August 24-26, Chicago. **Speaker:** Herond Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

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11th Annual Congress on CME
October 14-15, 1983
The Drake Oakbrook/Oak Brook, IL

CME Goals, Objectives and Evaluation: The Critical Link

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ICCME, 55 E. Monroe St., #3510, Chicago, IL 60603

Surgery

Fiberoptic Esophagogostric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, August 29-31, Chicago. **Speaker:** C. Thomos Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Urology

Endourology and Uretero-pyeloscopy
For: Urologists, Radiologists. Lecture, August 26-27, Chicogo. **Speakers:** Thomos John, MD; Irving Bush, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Reg. limit:** 60. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

SEPTEMBER

Emergency Medicine

Emergency Medicine: The Multiple Injury Potient
For: MD's, Surgeons. Symposium, Sept. 21, 1:00 p.m., Chester; **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Gastraenterolagy

Gastroenterology Symposium
For: MD's. Symposium, Sept. 15, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield. **Fee:** $45. **Reg. limit:** none **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Geriatrics

Geriotrics
For: MD's. Symposium, Sept. 22, 3:00 p.m., Robinson. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Internal Medicine

Hepatic Diseases
For: MD's, Surgeons. Symposium, Sept. 20, 7:00 p.m., Vondolia. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medical Humanities

Assessment Performance in the Clinic
For: residents, students. Symposium, Sept. 29-30, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

OB/GYN

Review Course
For: Obstetricions, Gynecologists. Course, Sept. 26-30, Chicago. **Sponsor:** University of Chicogo, 950 E. 59th St., Box 139, Chicogo 60637. **Fee:** $450. **Credit:** Category 1, 31 hours; ACOG cognotes, 31. **Contact:** Mory Ann Dillon. **Phone:** 312/962-1056.

Oncology

Oncology Symposium
For: MD's, Surgeons. Symposium, Sept. 23-24, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Ophthalmology

Pediatric Ophtholmology, Strobismus and Genetics
For: Ophthalmologists, Pediatricions. Symposium/workshop, Sept. 14-16, Chicago. **Speaker:** Dovid Cogon, MD. **Sponsor:** U of I College of Medicine, Dept. of Ophtholmology, 912 S. Wood St., 2N, Chicogo 60612. **Reg. deadline:** 8/31. **Fee:** $275, MD; $125, resident. **Credit:** Category 1, 15 hours. **Contact:** Sue Korienek. **Phone:** 312/996-8025.

Pediatrics

Core of the Seriously Ill Child
For: Pediatricions, Surgeons. Symposium, Sept. 21-22, Atkinson Hotel, Indionopolis, IN. **Sponsor:** Indiono University School of Medicine, CME, Indianopolis, IN 46223. **Contact:** Joni Downs. **Phone:** 317/264-8353.

Pediatrics

Seminars in Pediatrics
For: Pediotricians, FP's, Internists. Conference, Sept. 23-24, Madison, WI. **Sponsor:** U of WI—Extension, CME., 4658 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** TBD. **Contact:** Sorah Aslokson. **Phone:** 608/263-2856.

Psychasamatics

Psychosomotic Syndromes
For: MD's. Symposium, Sept. 8, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Cotegory 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Sparts Medicine

Sports Injuries
For: MD's. Symposium, Sept. 17, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Cotegory 1. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Weight Cantral

Weight Control Workshop
For: MD's. Workshop, Sept. 12-16, La Crosse, WI. **Sponsor:** La Crosse Exercise Program/Workshop, La Crosse, WI. **Fee:** $450. **Reg. limit:** 40. **Credit:** Cotegory 1, 35 hours. **Contact:** Philip Wilson.

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September 9-10, 1983
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Registration is limited to 24. The audience will learn through such learning opportunities as 1) small group discussions, 2) learning contracts and 3) teleconferencing and computerized techniques in learning.

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ORTHOPEDIC PHYSICIAN for Chicago and northwest suburbs wanted, must be board eligible or certified for evaluation center part-time. Hours flexible. Reply to Box #1081 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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INTERNIST W/WO SUBSPECIALTY: To join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, IL. 61032.

OBSTETRICIAN/GYNECOLOGIST: To join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

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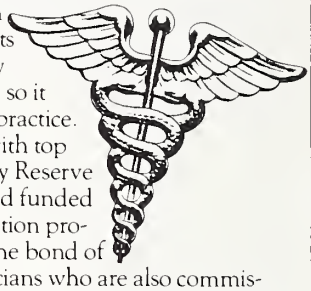
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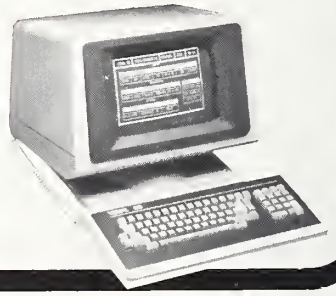
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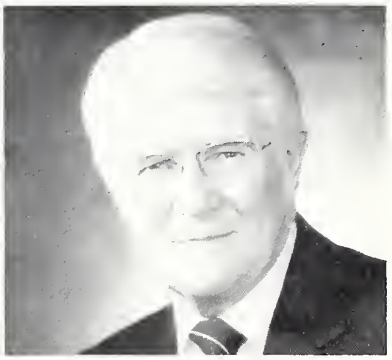
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President's Page

Preferred Provider Organizations



The Preferred Provider Organization (PPO) is a new regional approach to health care finance. A PPO is broadly defined as a group of independently practicing physicians, or a hospital, or a hospital and its medical staff. The group agrees to provide care to insured persons at a negotiated rate (often a 15-20% discount). Patients are not required to use the preferred providers, but other options usually result in higher deductibles and co-payments and sometimes result in higher fees. I would like to examine the PPO as it might affect the traditional physician-patient relationship. When a patient opts for a PPO, the following may occur alone or in combination:

(1) Patients may be limited in choice of either primary or referral physician.
(2) Patients may be limited in choice of hospital. If the patient's choice is not a preferred institution, use of that facility may be limited or surcharged.
(3) Patients may infer that the contract and discounted fee are automatically to their advantage. While a discounted cost does not imply lower quality care, neither should it be assumed to be better than that available from other physicians in the area.
(4) Systems based on discounts for hospital and physician services may create a further burden on both payers and patients who are denied access to such plans.

While evaluating the PPO structure, the physician might consider several aspects:

(1) Proponents assert that a PPO has something for everyone. It is claimed that a PPO can provide steady patient flow, increase volume, encourage prompt payment and eliminate bad debt. Supporters believe that a PPO can accomplish these things within the fee-for-service sector and in an increasingly competitive environment.
(2) The independently practicing physician may find that patients choose the discounted services for economic reasons.
(3) If the medical staff and hospital contract as a unit to provide full service coverage, staff physicians who choose to remain independent may lose some privileges and some patients.
(4) Utilization and peer review programs will require enhanced data gathering systems to ensure that quality of care concerns can be addressed.
(5) Cost cannot be given inappropriate emphasis. The physician must be directly involved in decisions regarding technological capabilities. It is possible that the PPO arrangement might discourage use of certain costly therapeutic or diagnostic procedures.

In summary, any attempt to address the cost and quality of medical care must be evaluated in terms of its effect on the physician-patient relationship. The helter-skelter drive to control health care costs cannot be permitted to erode our eminent concern for quality.

Robert P. Johnson, M.D.

Robert P. Johnson, M.D., President

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

August 1	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
August 1	ANCHOR	Chicago
August 3	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
August 3	Carle Clinic & Chgo. Lung Assn.	Urbana
August 3	Mercy Center	Aurora
August 15	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
August 18	American Cancer Society	Chicago
September 6	Little Company of Mary Hosp. & Chgo. Lung Assn.	Evergreen Park
September 7	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
September 13	Indian Trails Library & A.C.S.	Wheeling
September 19	Lutheran General Hosp. & Chicago Lung Assn.	Park Ridge
September 22	American Cancer Society	Chicago
October 3	ANCHOR	Chicago
October 3	Condell Memorial Hosp. & A.C.S.	Libertyville
October 3	Lake Forest Hosp. & A.C.S.	Lake Forest
October 4	St. Francis Hosp. & A.C.S.	Blue Island
October 4	Indian Trials Library & A.C.S.	Wheeling
October 5	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
October 12	St. Therese Area Trauma Satellite & A.C.S.	Lake Villa
October 17	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
October 20	American Cancer Society	Chicago
October 23	Victory Memorial Hosp. & A.C.S.	Waukegan
November 7	Lutheran General Hosp. & Chgo. Lung Assn.	Park Ridge
December 5	ANCHOR	Chicago

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nitedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PRDCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PRDCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PRDCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PRDCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PRDCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PRDCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nifedipine. PRDCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

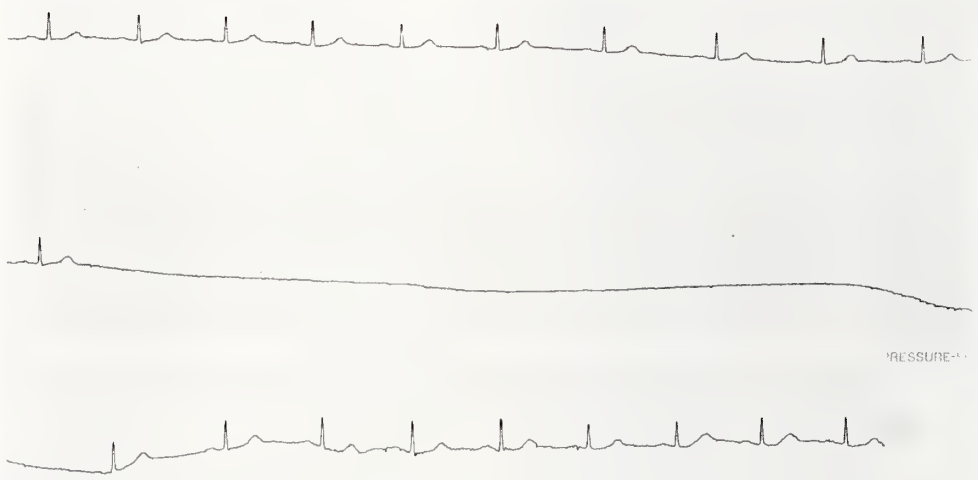
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Please see PROCARDIA *brief summary on adjoining page.*

EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a retired sixty-six year old executive who exercised regularly. In the past two months, he reported occasional spells of weakness. He thought there was some confusion associated with these episodes and this caused him great concern. None of these spells ever occurred during his exercise. An exercise session consisted of thirty minutes of continuous swimming in a pool three times a week with a forty minute weight training period on alternate days three times weekly. The spells tended to occur when he was at rest and never lasted more than several seconds. His physical exam was normal except for an occasional premature beat. An exercise ECG was normal. A twenty-four hour ambulatory ECG was ordered. The ECG rhythm strip shown was recorded during a spell.



Question:

1. **The ECG rhythm strip shows:**
   a. Complete atrioventricular (AV) block.
   b. A slow AV junctional escape rhythm.
   c. AV junctional rhythm with exit block of the junction.
   d. Severe sinoatrial block or sinus arrest.
   e. Sinus rhythm with first degree AV block.

2. **Proper management of this patient problem would include:**
   a. Digoxin
   b. Propranolol
   c. Quinidine
   d. Demand pacemaker
   e. None of the above

(Continued on page 14)

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Abstracts of Action

June 4, 1983

Arlington Park Hilton Hotel
Arlington Heights, Illinois

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

Leadership Conference

Based upon recommendations of the Task Force on Membership/Marketing, the Board agreed that a Leadership Conference should be held in Decatur, November 12-13. After broad discussion, the Board identified that several crucial issues would form the basis of a Leadership Conference. Among these are Health Finance, Professional Liability, Legislation and Public Affairs. Should there be a need for a House of Delegates meeting, it would be scheduled during the same weekend.

Building Committee

Due to the fact that the lease on current headquarters office space terminates in 1984, a Building Committee had studied various options. Following over six months of evaluation of proposals, investigating potential sites for the ISMS Headquarters, the Board adopted the following action:

> "That this Board recommend to the Board of Governors of the Illinois State Medical Inter-Insurance Exchange that they execute a 10-year lease with U.S. Equities for 34,650 sq. ft. of the 20 N. Michigan building at a rate of $18.50 per sq. ft., with a 10% limited partnership interest and sublease to the Illinois State Medical Society, contracting them for the management of the space, at market rate ($16.00 to $16.75) with the stipulation to U.S. Equities that the location can be turnkeyed for the Exchange without capital investment through investment by U.S. Equities or appropriate rent abatement. This recommendation is subject to review and concurrence by legal counsel."

DRGs

Of current interest and ongoing activity is the matter of Diagnosis Related Groups (DRGs). Various presentations having been made throughout the state, it was decided by the Board that a brochure briefly describing DRGs should be disseminated to the entire membership. In addition, the Board authorized two regional seminars July 27-28 (Chicago and Springfield) to reach as many members as possible with an in-depth expert presentation of DRGs and their impact on the practice of medicine.

(Continued on page 62)

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EKG

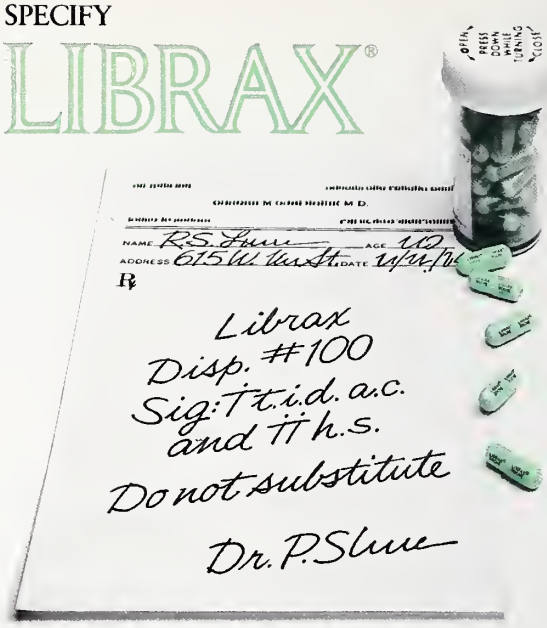
(Continued from page 8)

Answers: 1. D, E 2. D

The ECG shows sinus rhythm with a prolonged PR interval of 0.24 seconds at a rate of sixty beats per minute and sinus arrhythmia. The PR interval of 0.24 seconds allows a diagnosis of first degree AV block. All P waves are conducted. No junctional beats are seen. During the spell there is an asystolic period of over ten seconds. This is severe sinoatrial block or sinus arrest. In the clinical ECG, it is impossible to differentiate sinus node generator failure from severe or third degree sinoatrial block. This patient reinforces the point that the sick sinus syndrome is more than sinus node dysfunction. All subsidiary or escape pacemakers in the atria, AV junction, and the ventricles have also failed. No doubt this patient's good physical conditioning allowed him to tolerate these asystolic spells without more severe symptoms. A ventricular demand pacemaker was implanted and the patient became asymptomatic. The etiology of our patient's sick sinus syndrome is unclear. The etiology of the sinus node dysfunction may be the significant factor in the patient's prognosis. Pacemaker implantation alone in these patients has been associated with a high five year mortality rate approaching fifty percent in some series. However, this mortality is strongly influenced by the presence of coronary artery disease or valvular heart disease. ◀

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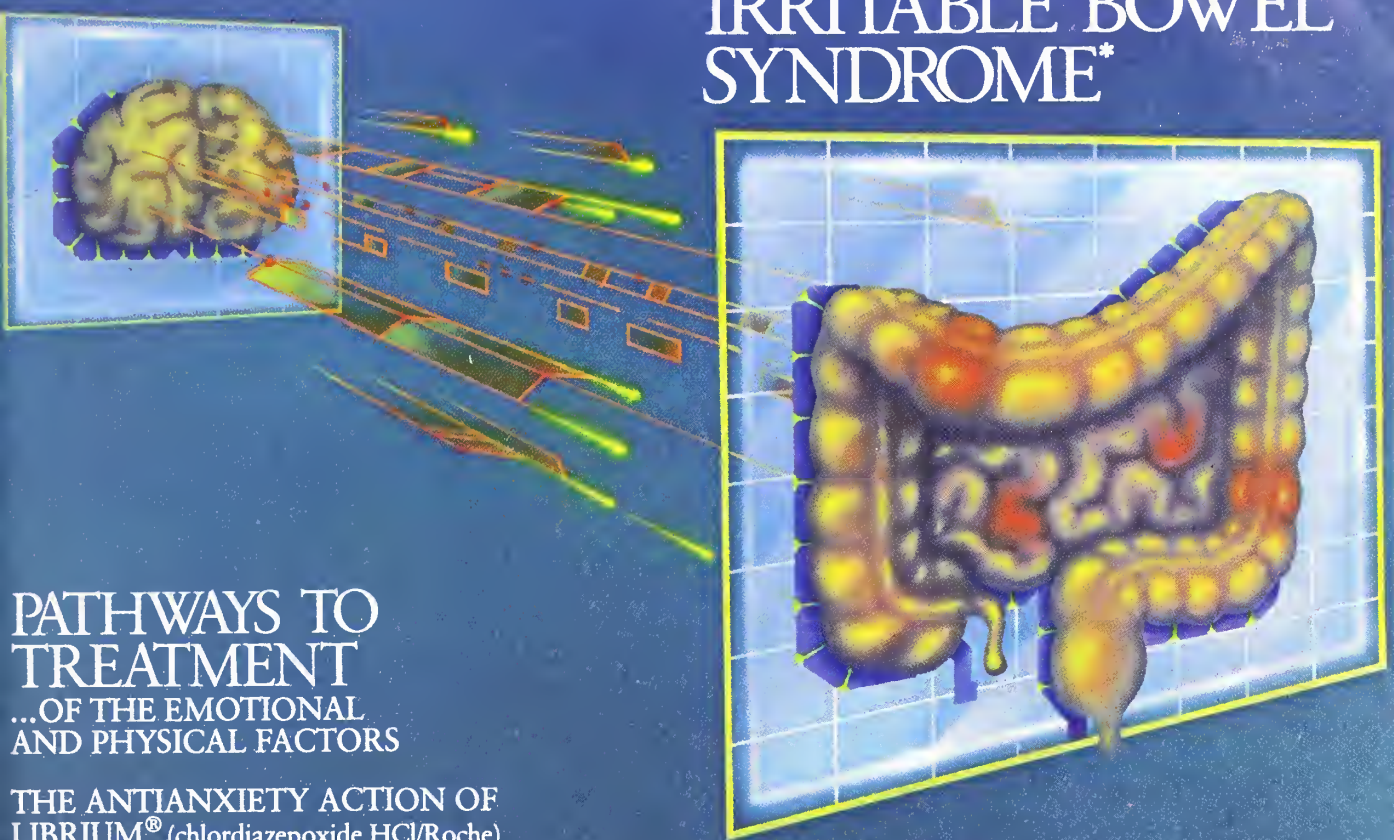
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References: 1. Sandler RS, Drossman DA: *Intern Med 2*(1):39-47, Jan 1981. 2. Mendeloff AI: *Practical Gastroenterol 3*(3):12-18, May-Jun 1979. 3. Connell AM: *The Female Patient 5*(9):20-22, Sep 1980.

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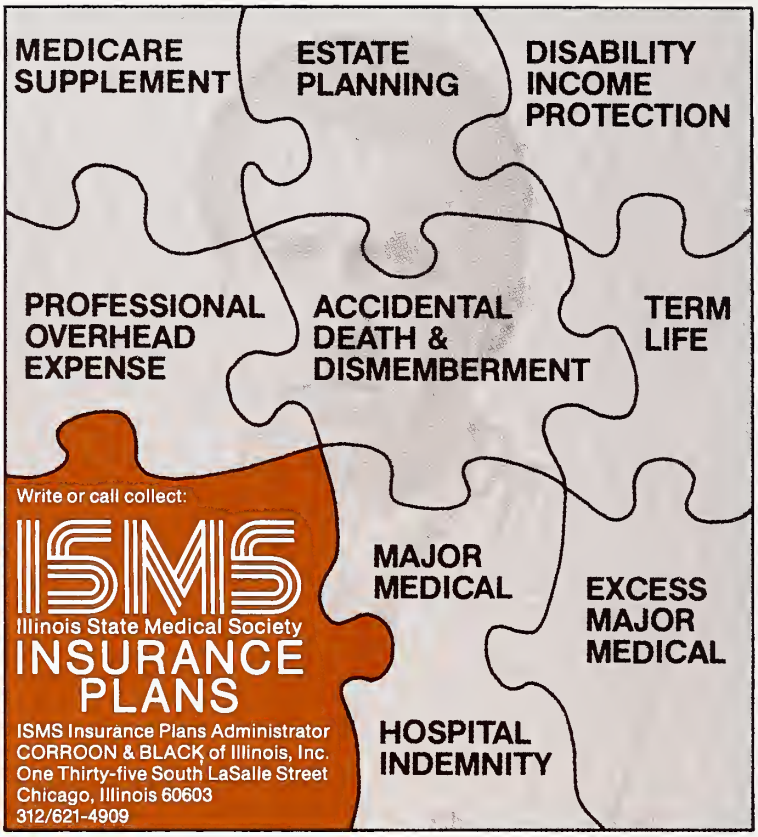
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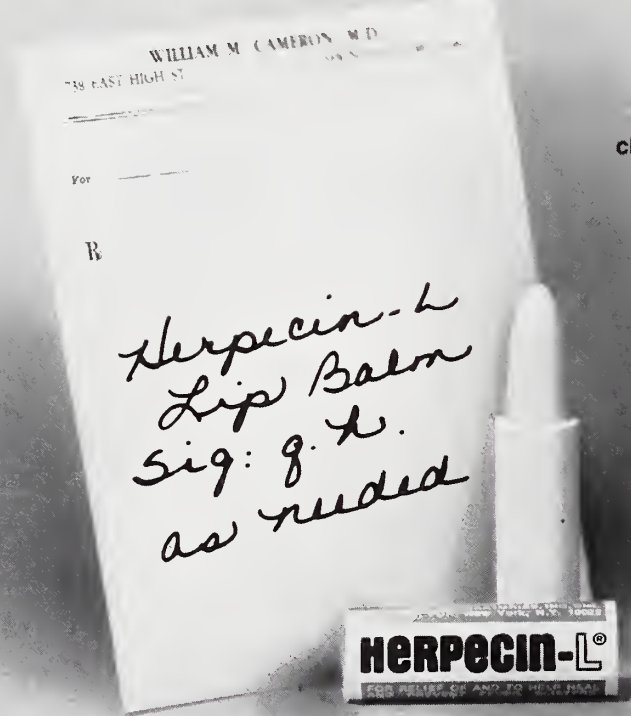
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Editorial

ALAS POOR YORRICK

Included in this issue of the *Journal* is a manuscript describing the writings of Egerton Yorrick Davis. After reading this manuscript and being thoroughly amused, I was immediately struck by the thought that perhaps it was a hoax, done in such a way as to *use a hoax to perpetrate a hoax.*

After a trip to the library to check references, my next thought was one of chagrin; to think that I had never heard of Egerton Yorrick Davis. McGill University of Montreal circulates a publication entitled "Osler Library Newsletter." Issue #38 of the newsletter, published in October, 1981, is dedicated to Egerton Y. Davis, the pen name invented by William Osler during the 1880's and used by him for many years to sign letters to the editor, book reviews, etc. Subsequently, others used the same pen name for similar activities. In all, 17 items are listed. In addition, no fewer than 55 references to EYD or his works are similarly listed.

As for my chagrin at being unfamiliar with the works of Egerton Y. Davis, it soon dissipated when I found little knowledge of his work among my colleagues, even those from Canada. Since we on the Editorial Board feel that medical history is important, it is altogether fitting that the readers of the *Illinois Medical Journal* become familiar with the writing of Egerton Yorrick Davis as summarized in this issue.

J.W. Roddick, Jr., M.D.
Chairman, *IMJ* Editorial Board

The Viewbox

CONTRIBUTING EDITOR TERRENCE DEMOS, M.D., ASSOCIATE PROFESSOR OF RADIOLOGY,
DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Howard Croft, M.D., department of radiology, Loyola University Medical Center, Maywood.

The radiographic findings in all four patients are due to the same disease.

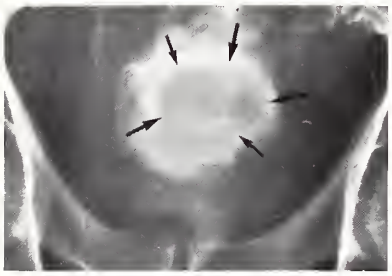


Figure 1
Cystogram shows large mass (arrows). This man had been receiving steroids for several months.

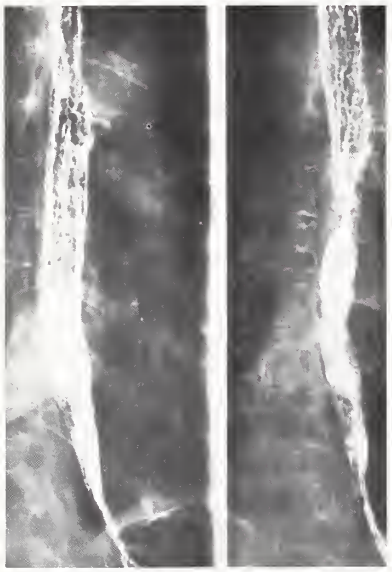


Figure 2
Esophagram shows numerous nodular filling defects. This woman was receiving chemotherapy for metastatic adenocarcinoma.

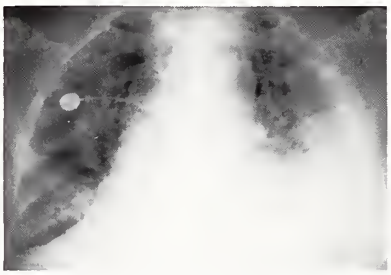


Figure 3
Chest radiograph shows extensive lung consolidation. This man was receiving chemotherapy for lymphoma. His chest was normal two weeks before this.

Your diagnosis?

(A) Tuberculosis
(B) Carcinoma
(C) Cytomegalovirus
(D) *Candida albicans*



Figure 4
Retrograde pyelogram shows irregular countours of the ureter which persisted. This woman had severe uncontrolled diabetes mellitus.

(Continued on page 59)

IMJ
Illinois Medical Journal
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Part II: Targeting Approaches

Approaches To Reducing Infant Mortality In Illinois

By Bernard J. Turnock, M.D., M.P.H. And
Laurilynn McGill, M.P.H./Chicago And Springfield

Although the infant mortality rate for Illinois decreased by one-third between 1970 and 1980, the Illinois rate remains 18% higher than the comparable national figure. This is the second of two articles considering the dilemma and solutions for Illinois. Part one was published in the June issue, beginning on page 415.

Three public health strategies seek to address infant mortality through their impact on either the neonatal or postneonatal components of infant mortality. The provision of preconception and prenatal health care acts to lower neonatal mortality by reducing the proportion of low birthweight infants among all births. Perinatal health care services also serve to reduce neonatal mortality, but act by improving birthweight-specific survival rates. On the other hand, infant follow-up services and health supervision during the first year of life exert their impact on postneonatal mortality rates.

Since resources to support extension or expansion of any of these three approaches have been limited in recent years, it has been necessary to focus or target the various program efforts to maximize their impact. Selective application of these approaches directed toward specific high risk population groups such as the indigent, unmarried, and adolescent populations, has become commonplace in maternal and child health programs.

Excess Infant Mortality

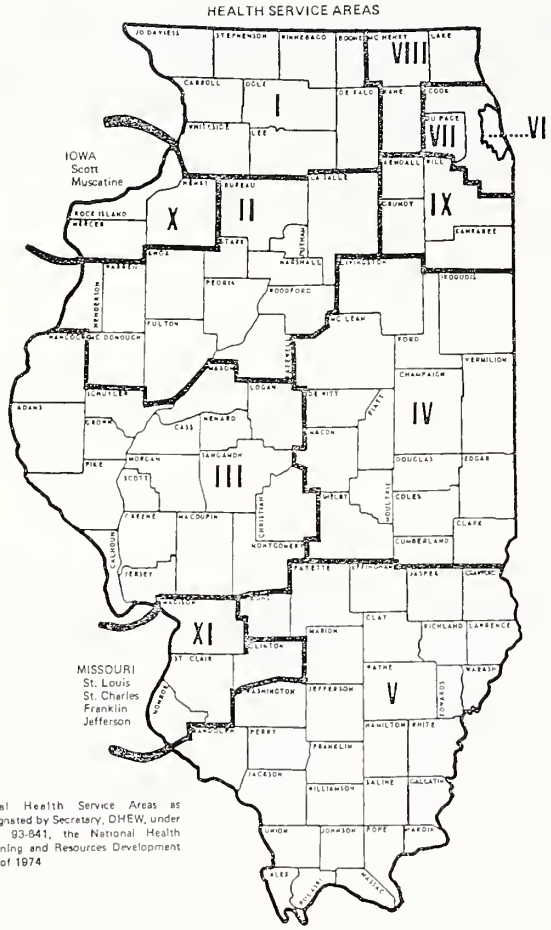
Another useful approach to targeting program efforts involves the concept of "excess" mortality.

Laurilynn McGill, M.P.H., is an evaluation specialist, division af family health, Illinois Department of Public Health, Springfield. Ms. McGill is a farmer pragram coordinator for IDPH and research assistant for the Health Services Research Institute, University of Texas Health Science Center.

Bernard J. Turnock, M.D., is a deputy cammissioner with the Chicago Department of Health. Board certified in preventive medicine and public health, Dr. Turnock was chief of the IDPH division af family health at this writing. Dr. Turnack formerly practiced pediatrics, and had served as assistant chief far the bureau of maternity services, New York City Department of Health.

Map 1

HEALTH SERVICE AREAS



Final Health Service Areas as designated by Secretary, DHEW, under P.L. 93-641, the National Health Planning and Resources Development Act of 1974

For example, it is possible to select the lowest infant mortality rate among the health service areas (HSAs) in Illinois (Map 1) and apply this rate to all HSAs to determine the expected number of infant deaths at this optimal rate. The difference between actual and expected deaths is then calculated and termed "excess." While this may be viewed by some as a superficial or artificial manipulation of data, it is useful in identifying the degree to which a problem exists in a given area and which area or areas contribute the most to the overall problem.

Using this concept for the 11 HSAs in Illinois, it can be demonstrated that 63% of the "excess" infant deaths occur in Chicago, 9% occur in the non-Chicago Cook County and DuPage area and 6% in the Illinois-Missouri area (Table 3). Together these three areas account for 78% of the "excess" infant deaths occurring in the state. It should be noted that more than half (51%) of all Illinois "excess" infant deaths occur among Chicago nonwhites.

Just as infant mortality can be analyzed in terms of its neonatal and postneonatal components, "excess" infant deaths can be subdivided into "excess" neonatal and "excess" postneonatal components. "Excess" neonatal deaths can be even further analyzed to determine the contribution of "excess" low birthweight and "excess" birthweight-specific mortality.

Excess Neonatal Mortality

The proportion of "excess" neonatal deaths among all "excess" infant deaths varies considerably among the three HSAs included in Table 3. More than three-fourths (76%) of "excess" infant deaths for the Suburban Cook-Dupage County HSA were neonatal deaths, compared with 62% for the Illinois-Missouri HSA and 57% for Chicago.

Further illustrating the usefulness of this method, we can examine "excess" low birthweight infants for these same areas. Surprisingly, the Cook-DuPage area has virtually no "excess" infants of low birthweight. However, 78% of all such "excess" low birthweight infants in the state are in Chicago (69%) and Illinois-Missouri (9%). Some of the implications of these findings will be discussed later in this review.

Excess Postneonatal Mortality

Extending this analysis for these three areas of Illinois, it can be shown that 43% of the "excess" Chicago deaths occur during the postneonatal period. This compares with 38% for Illinois-Missouri and 24% for Cook-DuPage. Virtually all the "excess" postneonatal mortality in Cook-DuPage occurs among nonwhites. The fact that more than 40% of the "excess" infant deaths in Illinois are postneonatal deaths underscores the rising importance of postneonatal mortality as a public health and social policy problem for our state. Postneonatal deaths from these three areas together account for nearly one-third (32%) of all "excess" infant deaths occurring in the state. The implications for public strategies to reduce infant mortality, however, would need to reflect the varying contributions of postneonatal mortality to the overall infant mortality problem in these areas.

Interpretation

Many of the implications from the preceding sections are readily apparent. While Cook-DuPage has "excess" infant deaths, these do not appear to be related to low birthweight and are less related to postneonatal mortality than in the other two areas. Perinatal health care services would appear to be a

Table 3
Number and Percent "Excess" Infant Deaths and Low Birthweight Infants: Illinois and Selected Health Service Areas, 1977-1979

	"Excess" Infant Deaths	Percent	% of "Excess" Infant Deaths Which are PNN	"Excess" LBW Infants	Percent
Illinois	2,784	100.0	40.4	5,272	100.0
Chicago HSA	1,749	62.8	43.1	3,652	69.3
Illmo HSA	175	6.3	38.4	496	9.4
Suburban Cook-DuPage Co. HSA	246	8.8	23.9	0	0
All Other HSAs	614	22.1	40.1	1,124	21.3

PNN: Postneonatal
LBW: Low birthweight
Excess Infant Deaths: Calculated using a standard reference rate of 10.35 infant deaths per 1000 live births
Source: Tabulations in Illinois Department of Public Health

greater need in the Cook-DuPage area than prenatal/preconceptional care or postneonatal follow-up care services. These latter two approaches appear to be more appropriate strategies for Chicago and the Illinois-Missouri area in their efforts to reduce infant mortality. Furthermore, since virtually all of the "excess" postneonatal mortality in the Cook-DuPage area occurs among nonwhites, the postneonatal follow-up care efforts would most effectively be targeted to that population group.

Similar analyses can help describe the most appropriate strategies for other areas of Illinois, but we should not focus only on those areas with the greatest numbers of "excess" infant deaths. There are pockets of poor pregnancy outcome in all parts of the state. For example, 1979 fetal and perinatal death data demonstrate that among the 102 counties in Illinois, only 23 had 10 or more fetal deaths. Of these, 9 had higher fetal mortality and 7 had higher perinatal mortality rates than Cook County.

Standardized Mortality Ratios

A useful adjunct to assessing the relative contribution of birthweight distribution and birthweight-specific mortality rates involves the calculation of standardized mortality ratios. This method compares actual with expected neonatal deaths, using a standard set of birthweight-specific mortality rates. Expected deaths are calculated for each birthweight category, generally in 500gm categories up to 2500gms, and then added together. The total observed deaths are divided by the total number of expected deaths to arrive at a standardized neonatal mortality ratio.

Ratios over 1.00 indicate that there are more deaths than would be expected, given the actual birthweight distribution of the area. Ratios less than 1.00 indicate fewer deaths than would be expected for that birthweight distribution.

High ratios suggest potential problems with the perinatal care delivery system and can point the way toward more refined analyses.

Preventable and Non-Preventable Deaths

A further refinement of the "excess" mortality concept has been employed by Hein[18] and others. These efforts seek to focus on potentially preventable deaths by eliminating non-preventable deaths. Examples of commonly accepted non-preventable deaths might include infants weighing less than 750gms, infants with major congenital anomalies incompatible with life and similar categories. Excluding these deaths from analyses focuses more appropriately on those infants who might benefit from health care system interventions. However, these analyses appear best suited for local or regional evaluation efforts which have access to more clinical data than is generally available from birth and death records.

Discussion

Selective application of the three public health strategies is based upon analyses of the population groups to be served and the current performance level of the service system. Indicators of the risk status of the target populations are readily available from vital records and census data bases. Indicators of the incidence of low birthweight, birthweight-specific mortality rates, and postneonatal mortality rates are also easily obtained. From this information the most appropriate approach or approaches for a particular region or community can be determined and tailored to local needs,

resources and priorities. Figure 1 includes a summary of the three approaches, as well as an outline of how they influence changes in the overall infant mortality rate.

Illinois currently emphasizes all three of these approaches to improving outcomes of pregnancies. All have been effective although the benefits of preconception/prenatal and postneonatal follow-up care programs have been masked by a relative increase in the population at risk. Especially important at the present time is the need to reverse recent trends toward increased rates of postneonatal mortality in Chicago, East St. Louis and certain other areas of the state. The resistance of postneonatal mortality and low birthweight rates among nonwhites suggests that future efforts must address the attitudes and behavior of health care consumers, as well as the characteristics of the service system.

While recent efforts in Illinois and elsewhere have focused on improvements in hospital-based perinatal medical care, and especially on the development of neonatal intensive care capabilities, fiscal constraints may prevent further improvements in outcome through this approach.[3] The increasing postneonatal mortality rate and the persistent high rate of low birthweight infants call for greater emphasis on strategies to address these problems in the future. The most sensible approach is to coordinate more closely preconception, prenatal, and postneonatal follow-up care with the ongoing perinatal health care system that has been responsible for so much of the improvement in infant mortality rates in recent decades. Such an approach calls for a widening of the circle of participants, and a firmer and more direct commitment to prevention services. This concept is certainly not a new one; it represents a restatement of the principles that have been espoused by perinatal leaders in Illinois as far back as 30 years ago.[17,19-21]

For further improvement in outcomes, future efforts must address other components of these perinatal systems of care. Public outreach and education, comprehensive family planning services, early identification of high risk factors, appropriate referral systems, transfers of high risk mothers to regional centers, professional education, family follow-up and family centered care are but a few of the components which have been both underemphasized and underfunded to date. Consequently, they remain underdeveloped.

Broadening the circle of participants to include a wider array of institutions, local agencies and all categories of providers and consumers involved with the antenatal and postneonatal components would ensure a more responsive perinatal system. Reallocation of resources to support these components, together with a broader and more vocal perinatal health constituency, is necessary to elevate prevention to at least the status of treatment. ◀

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Special Articles

New ISMS Student Loan Program

By The Task Force On Financial Aid To Medical Students

Some medical students are experiencing difficulty in borrowing money at reasonable interest rates to pay the rapidly escalating cost of medical education. The Educational and Scientific Foundation of the Illinois State Medical Society has established a revolving loan fund for Illinois residents enrolled in medical schools in this state. Guidelines for administration were recently approved by the ISMS Board of Trustees.

In anticipation of loan program activation for the fall semester of 1983, the Foundation, in conjunction with the ISMS Task Force on Financial Aid to Medical Students, has embarked on a fund raising effort to provide loans for Illinois medical students. To date, funds received from various sources total approximately $129,000. Included in this figure are individual donations from ISMS members and members of the ISMS Auxiliary, contributions from a recent benefit auction, and a generous bequest from a deceased ISMS member. We are particularly grateful for recent decisions made by the ISMS House of Delegates and the ISMS Auxiliary House of Delegates to allocate an amount from members' dues for the student loan fund annually.

Program Details

Eligibility. To be eligible for assistance through this program, a student must have been a resident of Illinois for at least five years and be enrolled in a medical school in Illinois. Initially, loans will be made only to students in their third or fourth year of medical school. Financial need of applicants will be determined by the financial aid officer of the respective medical school. Each year the financial aid officers will be asked to recommend for assistance those students in greatest need. Each Illinois medical school will receive $2,500 annually for loans, with additional funds when available.

Administration. The Task Force on Financial Aid to Medical Students will recommend to the Educational and Scientific Foundation Board the amount of money, in addition to the basic $2,500 per school, to be made available for loans at the beginning of each academic year. Initially, the amount available for loan at each school will be proportionate to the number of juniors and seniors enrolled. In order to compensate equitably for the differing tuition costs at each institution, the task force will make allocations of loan funds to each medical school based on student enrollment and relative costs for tuition.

Each medical school's financial aid officer will be notified early in the calendar year of the amount available for loans at that school in September. The maximum amount of each loan per student will be $2,500 and the minimum, $1,000 per year. Funds, in pre-determined amounts, will be forwarded by check to medical schools (or their appropriate agency or foundation) for distribution to individuals selected by the respective financial aid officers. Students receiving loans will be required to sign notes and have acceptable co-signers.

No repayment of principal or interest will be required while recipients are in school. However, simple annual interest will start accruing on the date the loan is made. Interest will be set annually at the most reasonable rate possible—consistent with administrative costs. Repayment of the loan and interest will be required beginning on January 1 of the first year of practice following completion of a postgraduate training program, but not more than five years after graduation.

Future Directions

In future years, as available funds increase, ISMS will be able to offer additional numbers of loans and possibily larger individual loans depending on available resources. In the meantime, the Educational and Scientific Foundation asks each ISMS member to consider seriously this new student loan program and to provide whatever contributions are feasible.

Among those groups from whom donations have been received and whose support is particularly important are the following:

*Members who will include the loan program as beneficiary in wills or through their estate planning

*Members of the Fifty Year Club willing to make direct donations

*Members who have completed their medical education and residency programs within the last ten years and are now in the position to assist their future colleagues

Questions about this program and/or donations may be addressed to the Division of Medical Education at ISMS headquarters. ◀

Seminars in Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

Giardiasis: An Overview

By Govinda S. Visvesvara, Ph.D./Atlanta, Georgia

Giardia lamblia, *the causal agent of giardiasis, is found all over the world. A bilaterally symmetrical, flagellated protozoan,* G. lamblia *usually resides in the duodenum and upper jejunum of humans, frequently causing acute or chronic diarrheal illness which sometimes leads to steatorrhea and malabsorption syndrome.* G. lamblia *is the most frequently diagnosed intestinal parasite in public health laboratories in the United States. As many as 23 waterborne outbreaks of giardiasis have been reported in the literature during the last 15 years. Various aspects of giardiasis, such as the morphology of* G. lamblia, *clinical features, pathology and pathogenesis, immunity, diagnosis, epidemiology, and treatment, are discussed.*

Giardia lamblia, the etiologic agent of giardiasis, was first observed by Leeuwenhoek in 1681. Since then it has been seen, described, and recorded from practically every part of the globe. Giardiasis is endemic in some parts of the United States, and according to some surveys, up to 15% of the adult population may harbor the parasite.[1] According to the Centers for Disease Control (CDC), *G. lamblia* is the most frequently identified intestinal parasite in the public health laboratories in the United States.[2]

Morphology, Cultivation, and Antigenic Structure

The life cycle of *G. lamblia* consists of two stages, a trophic or feeding stage, also called the trophozoite, and a resistant cyst stage. The trophozoite is pear-shaped and has a broadly rounded anterior end, a bluntly pointed posterior end, and a convex dorsal surface (Figure 1). It measures 9 to 16μm long, 6 to 10μm wide, and 2 to 4μm thick. A major part of the ventral surface is modified into a slightly concave, circular sucking disc. It has two vesicular nuclei in the anterior region. Each nucleus at the light microscope level has a densely staining endosome. At the electron microscope level, however, no endosome is discerned. *G. lamblia* has four pair of flagella; one pair emerge anteriolaterally at the broadest part of the body, one pair emerge laterally, one pair ventrally, and one pair caudally. The median bodies are the claw-hammer type and are located transversely across the middle line immediately posterior to the sucking disc (Figure 2).

The cyst is oval and measures 8 to 12μm long and 7 to 10μm wide. The mature cyst has four nuclei. Cysts are the infective stage and are transmitted from host to host through contaminated water and probably food.

G. lamblia usually resides in the duodenum and upper jejunum and obtains nourishment from the intestinal surface by absorption through its body surface. The parasite reproduces by binary

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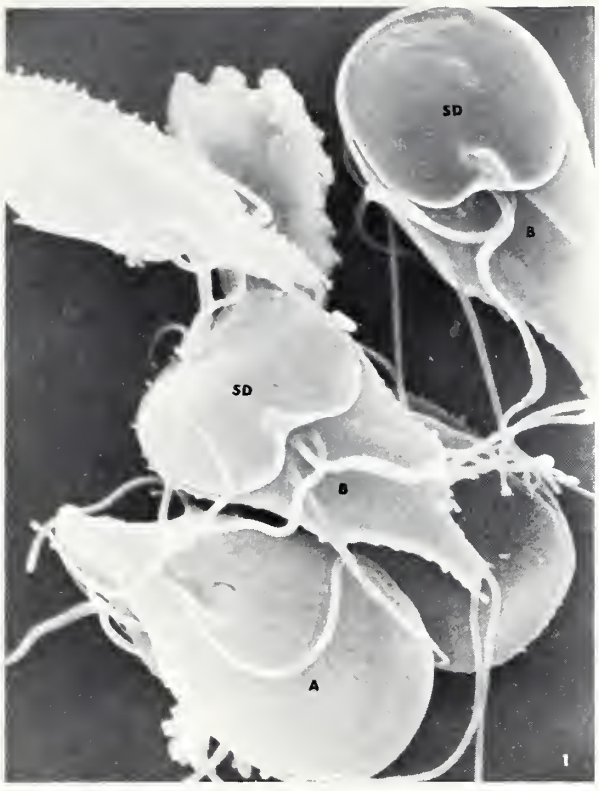


Figure 1
Scanning electron micrograph of axenically grown *Giardia lamblia* trophozoites. A: dorsal surface; B: ventral surface. Note the four pair of flagella, the ventral sucking disc (SD).



Figure 2
A trichrome-stained smear of *G. lamblia* showing the nuclei and the median bodies.

fission and sometimes colonizes the intestinal surface. It differentiates into the cyst stage during its passage from the distal part of the intestine to colon.

Even though *G. lamblia* was discovered almost 300 years ago, it eluded laboratory cultivation until recently. Meyer in 1976 was the first to cultivate the organism axenically in a liquid medium supplemented with 15%-20% human serum.[3] Because some batches of human serum caused growth inhibition of *G. lamblia* trophozoites resulting in loss of cultures, the parasites were adapted to grow in a trypticase-panmede-serum-(TPS-1) based medium that had been originally designed to grow *Entamoeba histolytica*.[4] Axenic cultivation has enabled investigators to obtain large numbers of organisms for use as pure antigen to produce hyperimmune sera against *G. lamblia* in rabbits.

The antigenic complexity of *G. lamblia* is shown in Figures 3 and 4. As many as 24 precipitin arcs are produced when electrophoretically separated antigens are allowed to react for 2 days with specific *G. lamblia* antibodies prepared in rabbits (Figure 3). More than 40 bands are, however, visualized when the antigens are focused on agarose gel containing carrier ampholytes with a pH range of 3-10 and stained with coomassie brilliant blue (Figure 4). Recently, Smith, *et al*,[5] using crossed immunoelectrophoresis and enzyme-linked immunosorbent assay, have shown subtle differences in the antigenic make-up of several human-derived strains originating from different geographic locales.

Clinical Features

Some individuals infected with *G. lamblia* are totally asymptomatic and excrete cysts regularly, thus representing a carrier state. On the other hand, others present a wide spectrum of clinical disease ranging from mild, self-limiting, nonspecific gastrointestinal disturbance to acute or chronic diarrheal illness, sometimes leading to steatorrhea and malabsorption syndromes. In rare cases, patients also suffer from lesions in the intestinal mucosa, tremendous weight loss, and profound lethargy.[6]

The acute stage of infection is characterized by the sudden onset of explosive, watery, foul-smelling diarrhea with very little mucous or blood. This is accompanied by epigastric pain, nausea, vomiting, anorexia, malaise, and sometimes, fever, headache, and nervousness. The acute stage usually lasts from a few days to 2 to 3 weeks, but it can persist for several months, often leading to secondary conditions like malabsorption and weight loss.[6]

The subacute or chronic stage is characterized by intermittent diarrhea with mushy, pale or yellowish, frothy, foul-smelling stools. It may be accompanied by anorexia, nausea, abdominal

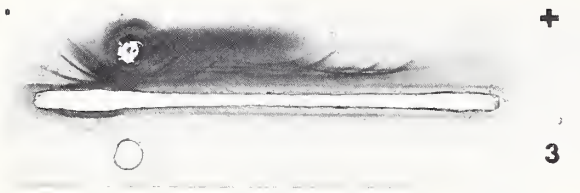


Figure 3
Immunoelectrophoretic pattern obtained by reacting the electrophoretically separated *G. lamblia* antigens with rabbit anti-*G. lamblia* serum. Anode at right.

bloating and discomfort. Belching, heartburn, and extreme lassitude are also seen in some cases. Sometimes urticaria and myalgia also occur. This type of infection can last for several months; it may be seen in people from nonendemic areas returning after extended trips to endemic areas *(e.g.,* travelers, peace corps volunteers) such as the Soviet Union, Mexico, South and Southeast Asia, West and Central Africa and western South America.[7]

Pathology and Pathogenesis

Histological examination of biopsy materials may reveal a wide spectrum of changes in the mucosal architecture. These include mild to acute focal inflammation of the mucosa, shortening and thickening of villi, hypertrophy of crypts, flat mucosa, and presence of increased numbers of chronic inflammatory cells in the lamina propria. Frequent association of giardiasis and patients with hypogammaglobulinemia (HGG), nodular lymphoid hyperplasia (NLH), and achlorhydria has been documented.[6-8] Inflammation and abnormal changes of the villus-crypt architecture have been reported in those patients with HGG and NLH.[8] Most of these changes are reversible as the mucosa returns to normal following appropriate treatment.[5,8]

The exact mechanism of pathogenesis is not clearly understood. Some workers believe that the parasite propagates at an enormous rate and completely covers the intestinal epithelium, thus creating a physical barrier which is therefore responsible for malabsorption. Others, however, have shown with the aid of light and electron microscopy that even small numbers of parasites lining the mucosa can cause malabsorption. According to some recent work, a synergistic activity between *Giardia* and concurrent infection with enterobacteria or fungus might be responsible for this pathogenesis. Recent scanning electron microscope studies indicate that the repeated attachment and detachment of the powerful sucking

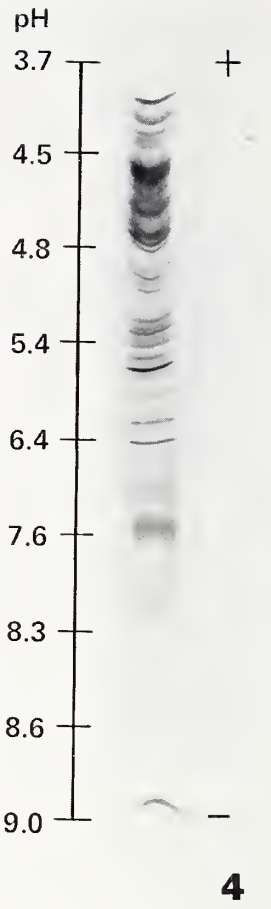


Figure 4
Isoelectric focusing in agarose gel of *G. lamblia* antigens in the pH range between three and 10.

disc of the parasite causes traumatization of the mucosal cell, resulting in irritation of the mucosa and damage to the microvillus architecture. Because of such damage, a significant reduction of the brush border enzymes, particularly lactase, sucrase, and leucyl-naphthylamidase, along with decreased absorption of Vitamin B12, can occur.

Immunity and Humoral Antibody Response

The facts that long-time residents of an endemic area such as Colorado have lower levels of symptomatic giardiasis than visitors,[9] the greater susceptibility of children born in Canada compared with children who immigrated from less developed countries where giardiasis is endemic,[10] and the high incidence of giardiasis in hypogammaglobulinemic individuals, suggest that acquired immunity may play a role in the lower incidence of giardiasis.

Using culture-derived trophozoites as antigens

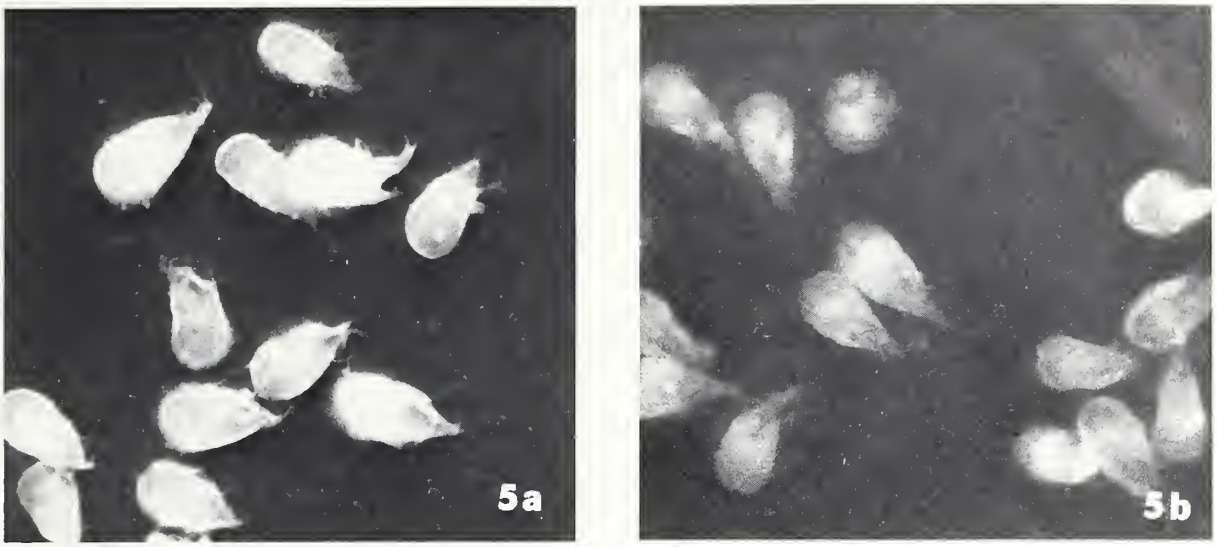


Figure 5

Indirect immunofluorescent staining of *Giardia lamblia* with serum from a giardiasis patient. A 4+ reaction at 1:32 dilution of the serum. Note the bright fluorescence of the entire organism including flagella (5a); at higher dilutions of the serum, fluorescence was confined to the surface membrane only. No fluorescence, however, was seen when the *G. lamblia* was similarly treated with 1:32 dilution of sera from normal healthy controls, and patients with amebiasis and trichomeniasis. (5b).

in the immunofluorescence test (Figure 5), serum antibody to *G. lamblia* has also been detected in patients with clinical giardiasis.[11] A majority (90%) of the serum specimens from these patients had titers of ≥ 32, whereas none of the sera from normal, healthy controls and patients with amebiasis and trichomoniasis had titers as high as 32. Treatment of positive sera with *G. lamblia,* but not with *Entamoeba histolytica, Trichomonas vaginalis,* or *Escherichia coli,* eliminated the specific antibody activity.[11] More recent studies carried out at CDC indicate that the *G. lamblia* antibody is mainly IgG and that it persists for several months following therapy. Smith, *et al.*[12] have obtained similar results using an enzyme-linked immunosorbent assay.

The role of serum antibody in protecting the host from subsequent infection is not clearly understood. It is, however, believed that both antibodies and T-cells play a role in the immune response to *G. lamblia* in immunocompetent individuals.

Diagnosis

Giardiasis can be diagnosed by demonstrating trophozoites and/or cysts in a stool sample. Cysts are usually found in the formed stool, whereas trophozoites and cysts can be found in the watery stool. Generally, direct microscopic examination of a wet-mount preparation of a fresh stool sample is adequate for demonstrating *G. lamblia* cysts or trophozoites. Sometimes a concentration technique, such as the formalin-ether method or zinc sulfate centrifugal flotation technique is necessary to demonstrate the cysts. If for some reason the stool sample cannot be examined immediately, it may be stored at 4°C for up to 24 hours or preserved in 10% buffered formalin or polyvinyl alcohol (PVA) fixative. Otherwise, the untreated stool sample, if left for prolonged periods at ambient temperature, will deteriorate, resulting in autolysis and disintegration of the parasites.[1] Since the patterns of excretion of *Giardia* cysts are so variable, 3 to 4 stool samples should be examined over a period of 7 to 10 days for a correct diagnosis. Even repeated stool examinations can sometimes fail to demonstrate the parasite, in spite of characteristic symptoms.[1] In such cases, examination of the duodenal contents collected either by intubation or the entero-test method may be necessary to make a diagnosis. A recently described counterimmunoelectrophoresis (CIEP) test[13] for detecting *G. lamblia* antigens in the fecal sample may become a useful diagnostic tool in the future. The CIEP test is purported to be as sensitive and reliable as the combined examination of feces and duodenal fluid.

Epidemiology

Epidemiologic studies carried out on tour groups returning from the Soviet Union have indicated that 23% of 1419 tourists from 1969 to 1973, 90% of 21 in 1973, and 40% of 179 in March 1975 were believed to have contracted giardiasis.[14] The illness usually occurred toward the end of the tour or shortly after their arrival in the United States. Tapwater in Leningrad was implicated as the source of infection.

As many as 23 waterborne outbreaks of giardiasis affecting more than 7000 people have occurred in the United States during 1965 to 1977.[14] Of these 23 outbreaks, nine have occurred in Colorado, three in Utah, two each in Montana, New Hampshire, and Vermont, and 1 each in California, Idaho, New York, Washington, and Tennessee. The Rome, New York, outbreak that occurred from November 1974 to June 1975 is unique because (1) it was the largest waterborne outbreak of giardiasis in the United States and affected 4800 people; (2) *G. lamblia* cyst was demonstrated microscopically in a city water sample and (3) *Giardia*-free beagle puppies became infected with *Giardia* after being fed with the sedimented water sample from the city reservoir. The city water supply was chlorinated but not filtered. *Giardia* cysts were also recovered from filtered and chlorinated water during the Camas, Washington and Berlin, New Hampshire outbreaks. Since 1977, several waterborne epidemics have occurred in California, Colorado, Montana and Pennsylvania. The Pennsylvania outbreak occurred during October-December 1979 and affected 407 residents in the city of Bradford. *Giardia* cysts were recovered from the water and also from beavers trapped in the reservoir. Since *Giardia* cysts have been recovered from stools of trapped beavers in many of these areas and since giardiasis can be produced in beagle puppies by feeding them with beaver *Giardia*, wild animals, particularly beavers, have been implicated as animal reservoirs for human *Giardia*.

In a recent outbreak of giardiasis that affected 29 people in Goodhue, Minnesota, food was implicated as a possible vehicle of transmission.[15] High incidence of giardiasis in day-care centers has indicated fecal-oral transmission of the parasite from person-to-person.[10,16] Venereal transmission of *Giardia lamblia* in male homosexuals has also been recorded.[17]

Treatment

Three drugs, quinacrine, metronidazole, and furazolidone, are available for the treatment of giardiasis in the United States.

Quinacrine, a member of the acridine drug group, is still the drug of choice.[6,7] The recommended dose for patients over eight years of age is 100 mg, three times a day (t.i.d.) for seven days, and 2 mg/kg t.i.d. for children eight years and younger. Cure rates of 90% to 95% have been reported with this regimen. Side effects, particularly in the younger children, are as follows: fever, yellowish tinge to the skin and urine, intestinal upsets, headache, dizziness, and an incidence of toxic psychosis of about 1.5%. This drug should not be taken with alcohol or with primaquine, nor by psoriasis patients.[7]

Metronidazole: This nitroimidazole derivative was introduced in the 1960's. The recommended dose for adults is 250mg t.i.d. for seven to ten days.[6,7] A cure rate of 70% to 85% has been reported with this regimen. According to some recent studies carried out in England, a single dose of 2g, once daily for three days, appears to be very effective, and a cure rate of 91% has been obtained. Metronidazole is fairly well tolerated. Occasionally, however, nausea, headache, metallic taste, dizziness, and dark discoloration of urine occur. It should not be taken with alcohol, as extreme nausea, vomiting and even collapse (disulfiram-like reaction) may occur. Metronidazole is carcinogenic in mice and mutagenic in bacteria.[7] It is not approved by the U.S. Food and Drug Administration for giardiasis.

Furazolidone is a nitrofuran derivative and a monoamine-oxidase inhibitor. It is available in both tablet and suspension form and hence is very useful in treating children. A cure rate of 77% has been obtained in children with a dose of 5 mg/kg per day divided into 4 doses for 7 days.[7] Although this drug is well tolerated, the following side effects may sometimes occur: vomiting, diarrhea, nausea, fever. It may cause hemolysis and a disulfiram-like reaction in glucose-6-phosphate dehydrogenase-deficient individuals. Other drugs such as Tinidazole and Ornidazole, both imidazole derivatives, have been used extensively abroad, with excellent cure rates. These drugs, however, are not available in the United States.

Prevention

No chemoprophylaxis is available for giardiasis. Travellers to endemic areas can avoid infection with *G. lamblia* by taking simple precautions such as drinking only boiled (for 3 min.) tap water or bottled water or other bottled

beverages. Ice, unpasteurized milk or milk products, peeled fruit and raw vegetables should be avoided.

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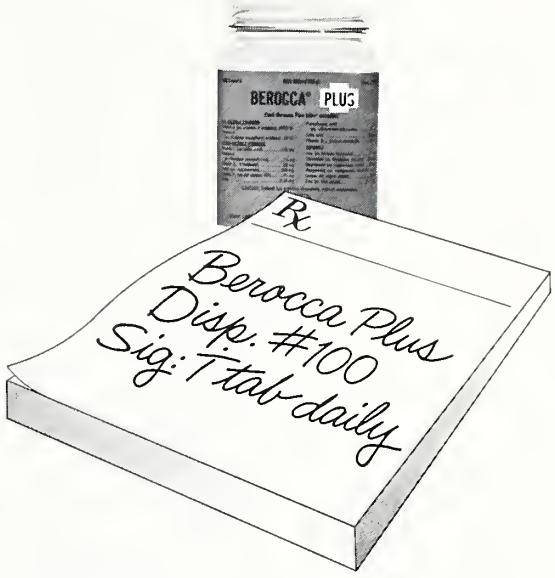
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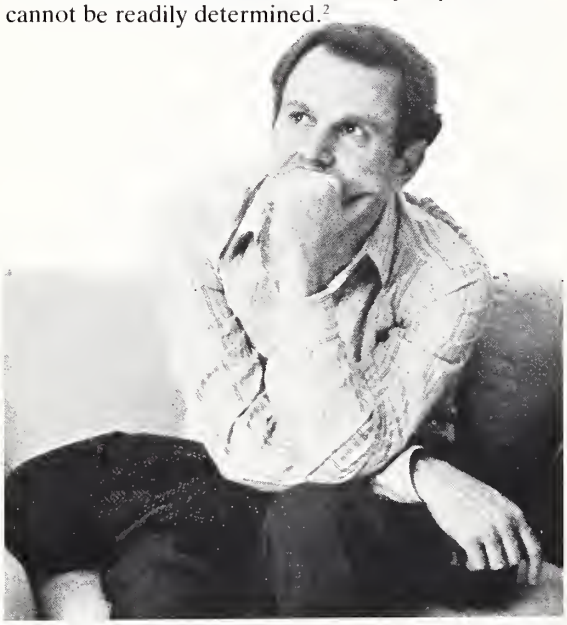
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Pulse of the ISMS Auxiliary

LEGISLATION

By Susanne Webb/ISMSA President

Why should we be concerned about legislation? Because the laws that are enacted by the legislature affect our lives by adding restrictions, regulations and requirements to the way in which our spouses practice medicine. Because we are concerned for the health care in our communities and physician input is vital in setting up criteria for that health care. Because if we take no active role in events, we have no right to complain about the results of those actions.

How can we assist our spouses in influencing the legislative process? By keeping informed of the bills pending before the legislature, both in the field of medicine and any other area, such as education, that is of personal concern to us as individuals. By becoming personally acquainted with our legislators, both state and national. By corresponding with our elected representatives.

When should we contact our legislators? We should write when a bill comes up for discussion and/or when it comes to the vote. A brief telephone call may be in order. Ask for your representative's vote and give a concise and valid reason for doing so. We should also write our legislators to commend them for a vote well cast. A brief thank you is always appreciated. Mention your admiration of his/her demonstrated concern for the well being of constituents.

What else can we do? During election times we can support the legislator of our choice with financial contributions and volunteer hours working in their campaigns answering telephones, distributing literature and doing whatever will help them get elected. Remember a few years back when the slogan "take your legislator to lunch" was popular? Make an effort to visit Springfield. While there, visit your legislator; take him to lunch; get to know him personally. It is not only easier but also more effective to talk to a friend. ◂

Special Articles

An Introduction To The Writings Of Egerton Yorrick Davis

By John L. Graner, M.D./Hines

At least two articles have previously been written about Egerton Yorrick Davis. These dealt with only the little-known aspects of his career, assuming, perhaps, that the reader was already acquainted with Davis' works. Sadly, however, even the better-known writings of Egerton Yorrick Davis are now largely forgotten. This is unfortunate, since they shed considerable light upon the personality of Davis' creator, modern medicine's greatest figure, Sir William Osler.

Davis made his first appearance in 1880 as an obscure ex-army surgeon from Caughnawaga Canada, and over the years was periodically to reappear in the literature as a "pathological fabricator of ill repute."[1] EYD was, in fact, William Osler's less than serious alter ago, writing upon those occasions in which Osler chose, for obvious reasons, not to use his own name. EYD's works, to the consternation of some of Osler's more "level-headed" colleagues, were appreciated by those who shared his love of practical jokes. The following is a description of EYD's four contributions to the medical literature.

Obstetrics At Great Slave Lake

Davis' first work was written at least in part to embarrass W.A. Molson, the co-editor of the *Canada Medical and Surgical Journal.* Molson was a close friend of Osler, who was then a young professor of medicine in Montreal. Many variations of the story exist and one of the more popular is something like this:

As the secretary of the "most distinguished medical society in Montreal," Osler was often impressed by the verbosity of its members. It seemed that regardless of the case presented at their meetings, certain members would have little difficulty outdoing it with exaggerated personal experiences of their own. As a means of "discovering the sham," under the guise of EYD, he wrote a rather lengthy paper entitled "Professional Notes Among the Indian Tribes About Gt. Slave Lake, N.W.T." This paper, purporting to describe some rather unique obstetrical practices of said tribes, was read at a society meeting by Osler himself, after a rider informed the gathering at the last minute that Davis was unavoidably detained. The bogus report engendered great interest among the society members, and led several to relate their own similar observations and experiences.[2]

Whether the preceding legend regarding the medical society meeting is actually true is doubtful, as Osler himself stated that the editorial from which it came,[2] written by Bayard Holmes, contained "all the essentials but the truth," and indeed many obvious inaccuracies are present in the above-mentioned piece. At any rate, we do know that Davis' communication went on to be accepted by Molson for publication in his journal. Only after Osler write "Joke on Molson" across the manuscript, which he located in the printer's office, was the ruse discovered.

A Unique Case of Vaginismus

Molson was to have his revenge when Davis' second effort appeared in 1884 while Osler was professor of medicine in Philadelphia. Parvin of the *Medical News* was much interested in the actions of the perineal muscles, which resulted in an editorial appearing in the November 29th issue of that journal, entitled "An Uncommon

JOHN L. GRANER, M.D., is a board certified internist affiliated with Hines Veterans Administration Hospital. Also an endocrinologist, Dr. Graner is chief of the general medical clinic at Hines. In addition he is an assistant professor of medicine, Loyola University Stritch School of Medicine.



Form of Vaginismus."[3] The article mentioned a rare condition in which "the penis was retained captive by (the) woman's genital organs." The editorial then went into considerable detail regarding which muscles could have been involved, etc.

It is easy to understand why this editorial was just too much of a temptation for EYD, and in the December 13th issue of the same journal, "through the courtesy of the editor of the *Canada Medical and Surgical Journal*" (Molson's revenge!) appeared a letter simply entitled "Vaginismus" and signed "Egerton Y. Davis, ex US Army, Caughnawaga, Quebec."[4]

An example of EYD at his best, the communication describes a man's discovery of his coachman and maid together in bed. Upon being discovered, the coachman found to his horror that he could not extricate himself from the Maid's vaginal orifice. She was described as much smaller than the burly coachman and "in great agony." To quote EYD:

"When I arrived I found the man standing up and supporting the woman in his arms, and it was quite evident that his penis was tightly locked in her vagina, and any attempt to dislodge it was accompanied by much pain on the part of both. It was indeed, a case 'De cohesione in coitu.' I applied water, and then ice, but ineffectually, and at last sent for chloroform, a few whiffs of which sent the woman to sleep, relaxed the spasm, and relieved the captive penis. . . ."

Parvin was said to have been delighted upon receipt of the letter, as it described a case "just such as he thought possible." Osler's prank was only discovered after the journal was printed, to the disgust of the editor, Minis Hays.[5]

Debunking A "Competitor"

Davis' third contribution to the medical literature was an unusually serious one. Published in the *Medical News* of March 6, 1886,[6] this letter debunks a previous paper from that journal, which Davis must have regretted not having written himself, entitled "Extrauterine Changed to Intrauterine Pregnancy by Electricity." The letter is signed simply with the initials "EYD." (These initials probably referred to EYD Jr, as Osler clearly stated that EYD senior was drowned in the Lachine Rapids in 1884.[5])

Strabisme Du Penis

A letter dated February 14, 1903, appearing in the *Boston Medical and Surgical Journal*, was the Davis family's fourth and last appearance on the literary scene. It can be seen that by this time junior was following closely in his father's footsteps, describing a case of "Peyronie's Disease-Strabisme Du Penis," termed "squint of the cock" by the afflicted patient.[7] The paper describes a genuine case of this disease, with a unilateral fibrous plaque of the corpora cavernosa causing the patient's erect penis to curve in a semicircle. It was written by Osler (as Davis), but signed "J.W.W. Jr" for Osler's Pittsburg friend J.W. White. White's reply letter, denying that anyone from Pittsburg would write such a letter on Valentine's Day, was signed "ETD Jr" (misspelling of "EYD Jr").[8]

In addition to the above more widely known contributions of EYD, Osler often used his pseudonym when checking into hotel rooms in order not to be disturbed, and in communications to friends and relatives.[9-11] Even the tragic death of his son in World War I did not prevent EYD's appearance in Osler's numerous personal letters. After Osler's death, his friends and admirers carried on the tradition, occasionally using the Davis name in their private correspondence.[10] In time EYD came to be a well known symbol of the lighter, more humorous side of Sir William Osler.[10]

Acknowledgment

Special thanks to the staff of the Hines VA Medical Library for their kind assistance in procuring some needed references, especially to Mrs. Mary Ellen Klupping and Mrs. Rose Fingeret.

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The Real E.Y. Davis

In addition to his mythical adventures under the *nom de plume* of Egerton Yorrick Davis, Sir William Osler, M.D., established a reputation as a highly-respected physician and scholar.

Born in 1849 in Bond Head, Ontario, Osler was the son of a canon of the Church of England. He steered away from early inclinations to join the clergy and entered the field of medicine. There he would gain universal respect as a noted author, revered teacher, fine physician and gentle friend of considerable observational skill and sharp wit.

Osler graduated McGill University in 1872 and later served there as a professor of the Institute of Medicine. In 1884, he was named a professor of clinical medicine at the University of Pennsylvania.

In 1889, a professor of medicine at Johns Hopkins University and chief of staff at Johns Hopkins Hospital, he quickly became known as a leader in the advancement of medical instruction and the improvement of hospital care. He argued against the reckless use of new treatments and drugs. He encouraged the use of students as assistants in hospital wards; Osler greatly believed in the learning value of first-hand experience and the rewards of direct observation.

Nicknamed "Chief" by friends and students, Osler continued his scholastic career by returning to Europe in 1905 to become a regius professor of medicine and student of Christ Church at Oxford. Throughout his teaching career, Osler favored informal bedside discussions rather than staid lectures. His engaging manner was appreciated by students and patients alike.

Lady Osler was a good-natured person and favorite of her husband's friends and students, gaining the nickname, "Mrs. Chief." She joined Sir William in entertaining house guests at afternoon tea, which was generally a small and intimate get-together of 40 or 50 people. They had one child, Edward Revere.

Countless anecdotes about Osler are familiar. While he was known as a man who disliked gossip and name-calling, he was not above a harmless, good-humored prank. Writing in "Osler and Other Papers," William Sydney Thayer relates this story: "One day, soon after arriving in Baltimore, he dropped in to see his distinguished colleague, X, like himself a bachelor. When the excellent hostess, who looked up to X as did all, with unbounded respect, said that he was not at home, Osler asked for 'Mrs. X and the children.' Before the amazed lady had an opportunity to explain, he apologized profusely and, in feigned confusion, hurried away."

And, again as Thayer reports: "During his Philadelphia days a patient had been sent to him from Canada, an exceedingly attractive and highly neurotic woman, who was transferred to his friend Doctor S. for a rest cure. At the consultation, as, in the presence of S., he said good-bye to his patient, she suddenly threw her arms around his neck and kissed him. He escaped and went, immediately, to the Philadelphia Club, where, to a group of friends, he told the whole story—*about* S. Later in the day when S. sought to tell the true story about Osler, he was greeted with derision."

This side of Osler appeared often in the form of the apocryphal author Egerton Yorrick Davis. Osler's serious side remains intact through the number of biographies written about him and through his own serious writing. In 1892, Osler wrote the renowned treatise, "The Practice of Medicine." He also authored several shorter pieces, such as "Chorea" and "The Cerebral Palsies of Children." His avocations included history, biography, public speaking and botany.

Toward the end of his life, Osler returned to England and continued teaching. It was also near the end of his life that his son died tragically on a battlefield of the First World War. The loss was a great shock to Osler and his wife. Many commented on his ability to show good will above his sorrow.

Osler continued as he had done all along—observing, learning, amusing and living. His death came on December 29, 1919, but the memory of his life lives today in his books and in the spirit of his example. As Thayer wrote: "Wherever Osler went, the charm of his personality brought men together, for the good in all men he saw, and as friends of Osler all men met in peace." ◂

Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR, M.D., CONTRIBUTING EDITORS

Epiphrenic Diverticulum

Surgical Grand Rounds are held weekly on Tuesday, 5:00 PM in the Offield Auditorium of the Passavant Pavilion of the Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of October 27, 1981.

Dr. Linda Goluch: A 62-year-old white man was admitted with a three-month history of progressive dysphagia. For one month, he had been able to swallow only liquids. He had had difficulty swallowing liquids in the week prior to admission. The day before admission he could not even swallow his own secretions. He was known to have an epiphrenic esophageal diverticulum which had been followed for approximately one year. Because he was asymptomatic and had several other medical problems, treatment was not recommended.

The patient had lost about 25 pounds in the past three months. He was extremely cachectic and malnourished. Intravenous hyperalimentation was instituted during his work-up in the hospital. A chest X-ray revealed a double shadow behind the heart. Work-up included a rather dramatic upper GI and esophagram (Figures 1 and 2). In addition to the upper GI, he had esophageal manometry, which revealed diffuse esophageal spasm. The probe could not be passed into the stomach because of a very tight esophageal sphincter.

After two weeks of hyperalimentation, he was taken to the operating room for excision of the pulsion diverticulum and a long esophageal myotomy. Because of a history of severe rheumatoid arthritis and known cricoarytenoid arthritis, which had required a tracheostomy during previous surgery, a tracheostomy was performed under local anesthesia. Under general anesthesia, the diverticulum was excised and the myotomy was carried out from the level of the aortic arch to the esophageal sphincter. The patient did well postoperatively. He began drinking clear liquids on the seventh postoperative day and was quickly advanced to a regular diet. A postoperative barium swallow showed a patent gastroesophageal junction and no leak. He was discharged 14 days after surgery.

Dr. John Moran: This man had been followed for years in the arthritis clinic for extensive rheumatoid arthritis. Surgical intervention was delayed because of the deforming arthritis. The most pertinent finding in his preoperative evaluation, in addition to the X-rays, was the fact that he had good pulmonary function. Many patients with advanced rheumatoid arthritis have markedly restricted chest



Figure 1
Barium study of the esophagus demonstrated a large diverticulum at the lower end of the esophagus, just above the diaphragm.



Figure 2
Lateral view of barium study of esophagus demonstrated origin of diverticulum and dilatation of esophagus.

motion virtually without chest excursion and almost pure diaphragmatic breathing. However this man had almost no chest involvement. We had little hesitation in recommending surgery for him.

He lost 25 pounds in ensuing months and became a much poorer surgical risk. For this reason, two weeks of parenteral hyperalimentation were scheduled to improve his nutritional status prior to surgery. The need for a preoperative tracheostomy was determined from his history. He had previously had a cholecystectomy and had done well through the operation. Apparently, he had extubated himself in the immediate postoperative period, and could not be reintubated. The reason for this was cricoarytenoid arthritis and an emergency tracheostomy was required. He was slightly hoarse but that was the only physical sign of this problem. We began the operation with a tracheostomy under local anesthesia to prevent the need for another traumatic intubation in the postoperative period.

Epiphrenic diverticulum is an unusual esophageal condition. I doubt that you will see a more dramatic demonstration of an epiphrenic diverticulum than the one presented today. The patient was almost totally obstructed. The symptomatology is related to two factors: the mechanical effects of the epiphrenic diverticulum and the underlying esophageal motor problem.

An epiphrenic diverticulum is a pulsion diverticulum usually associated with some other esophageal pathology. The most frequent associated problem is diffuse esophageal spasm or achalasia. About 20% of these are associated with hiatus hernias. An occasional cancer is encountered. Dr. Craig will address some of the problems in management and diagnosis.

Dr. Robert Craig: I first met the patient last winter when he was having some problems with regurgitation of undigested food. An esophagram showed the epiphrenic diverticulum. At that time,

he really was not troubled with dysphagia at all. He underwent upper endoscopy, which demonstrated the lower esophageal diverticulum very nicely. I was able to go into his stomach quite easily at that time and no other abnormalities were found. Because his symptoms were minimal, surgical treatment was not recommended. There was some increased risk because of pulmonary problems and a severe rheumatoid arthritis, which made walking difficult. Over the three months prior the summer visit, he had increasing problems with spasmodic dysphagia. He had intermittent total dysphagia and then would not be troubled.

Usually, when someone has intermittent total esophageal dysphagia, we think of either lower esophageal ring or a motility problem, such as diffuse esophageal spasm. I now think that diffuse spasm probably contributed a great deal to his intermittent total obstructive dysphagia.

I think another important aspect in symptom genesis was that when food would enter the diverticulum it would act as a flap valve. When esophagoscopy was performed, the instrument entered the diverticulum and it would be very hard to find his lower esophageal sphincter area. The food would get into the diverticulum which would fill up and descend. The opening between the diverticulum and the G-E junction would close off. Probably, some critical level of increase in the diverticulum size made his symptoms much more severe, so that he eventually developed dysphagia.

If surgical intervention is to be undertaken, it is very important to know whether or not diffuse esophageal spasm is present. If diffuse esophageal spasm is found, a long myotomy of the esophagus is needed in addition to the removal of the diverticulum. If a long myotomy is not performed then the same basic problem remains, and the patient may have recurrence of his diverticulum or may have persistent symptoms from his diffuse esophageal spasm. Motility studies in this patient demonstrated both simultaneous and repetitive contractions, which are typical of diffuse esophageal spasm. It would have been desirable to get the catheter into the lower esophageal sphincter area so we could have studied the dynamics of the lower esophageal sphincter. But we did demonstrate diffuse esophageal spasm, which did influence what Dr. Moran did at surgery.

Dr. John Moran: Because this patient did not have an associated hiatus hernia, and because we had no evidence for reflux as part of the etiology, we elected not to do a fundoplication. Instead we removed the diverticulum and did a long myotomy. The overall results of surgery in this condition are reasonably good. In recent years, gastroenterologists and surgeons have become aware of the

(Continued on page 61)



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The increasing numbers of students in organized medicine *are* making a difference.

We are making a difference in the state society when the student perspective is sought out, welcomed and discussed, even though it may be unfamiliar to many physicians. These exchanges of ideas, problems and experiences are helping to keep practicing physicians aware of the tremendous changes and trends in medical education. They also let students know that they are not the first to find the system stressful, demanding and physically exhausting.

Medical schools and students benefit by having peers who are up to date and informed about the realities of medical practice today—these students bring an enlightened perspective to discussions ranging from practice opportunities to reimbursement. Many students involved in organized medicine also serve in student government at their schools; in doing so, they bring leadership skills learned in county, state and national medical society meetings.

Through our own Medical Student Section, we are learning the leadership skills necessary to protect and change our futures. Early on, each of us learned the benefit of the organized approach to our profession and that by discussing problems and airing differences with our peers, sounder solutions could be reached. Organized students have also learned to function effectively in teaching other students subjects not contained in traditional medical school curricula, but nonetheless necessary for the open minded practice of good medicine. In contrast to our earlier simplistic solutions, we are learning the complexities behind many issues such as peer review, licensure, competition and public health.

Most important, the difference is seen in the individuals who are involved themselves. Despite the complexity of issues or previous unsatisfactory results, our thoughts and activities give a sense of worth and accomplishment. Learning that the process of change is long and arduous has dissuaded few and our successes are attracting many. Our students interact with many physicians who are experienced in the mechanisms of change and our reactions are often impetus for further action. It is invigorating to know that hard work and preparation make a difference—not only to us now, but for our patients and our profession.

Why let learning stop within the walls of a school, especially in a profession so affected by the world around it? More and more students are learning that they can initiate change—and their learning *is* making a difference. ◀

Linda Tetzlaff Brubaker
Chairman, ISMS Medical Student Section

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Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

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On Saturday evening, April 23, ISMS officers, trustees, delegates, members and guests gathered for an evening of great fun honoring outgoing President Cyril C. Wiggishoff, M.D. Can you identify the guests in these photographs from President's Night 1983?







Illinois Society, American Association of Medical Assistants

Non-Traditional Benefits For Medical Assistants

By Lesa B. Greene, CMA-C/River Grove

Increasing numbers of physicians are realizing the value of competent medical assistants. Medical assistants are also becoming more selective about prospective physician/employers. The following information is designed to give physicians means to attract quality medical assistants and provide incentives to retaining quality personnel.

Traditional benefits that have been extended to medical assistants include providing the employee with: paid vacations and sick days, insurance benefits (death, life, and major medical, to name a few) and time and a half for overtime hours.

In my professional contacts with several medical office managers in the Chicago area, I have noted some non-traditional benefits, as well. These include: (1) pension and profit-sharing; (2) free medical care and reduced lab costs for the employee's immediate family members; (3) reimbursement for the application fee upon successful completion of the national certifying examination; (4) additional compensation for medical assistants who become certified; (5) payment of dues in the American Association of Medical Assistants organization; (6) time off with pay to attend relevant continuing education workshops; (7) paid registration to professional society conventions; (8) tuition reimbursement plans; (9) employee awards for exemplary performance on the job and (10) parking fees, and/or mileage reimbursement when assigned to several facilities

The benefits I have delineated are at varying costs to the physician/employer. However, many are tax deductible. While it may not be feasible to offer all of these benefits to your employees, each suggestion merits careful consideration. Advantages derived from many of these benefits will serve to make the medical assistant a more valuable employee and in doing so further enhance the professionalism in the office.

Information regarding Illinois Society, AAMA, may be obtained from Betty Kronemeyer, CMA, President, Illinois Society, 809 North 10th Street, Mascoutah, IL., 62258, or Lesa B. Greene, CMA-C, Chairman, Public Relations Committee, 8836 West Grand Avenue, River Grove, IL., 60171. ◀

Viewbox

(Continued from page 18)

Diagnosis: *Candida Albicans*

Three patients had extensive lesions. All four patients were subject to opportunistic infections because of diabetes mellitus in one patient and various types of drug therapy in the others.

Carcinoma can cause extensive involvement of the esophagus but that would be squamous rather than adenocarcinoma. Squamous carcinoma can be superficial and extensive, but adenocarcinoma usually involves only the distal esophagus by direct extension from tumor primary in the stomach. Transitional cell carcinoma of the ureter and (rarely) metastases to the ureter can be extensive. Lymphoma, alveolar cell carcinoma, and lymphangitic lung metastases can all produce widely disseminated lung lesions.

Tuberculosis can cause extensive ureteral and lung lesions but diffuse esophageal involvement is a rarity. Cytomegalovirus may present with diffuse lung nodules which later become confluent, but this virus doesn't cause extensive ureteral or lung lesions.

Candida albicans is a frequent cause of opportunistic infection. It can cause a fungus ball as in the first patient or disseminated disease as in the other three patients. The histories and radiographic findings fit best with *candida albicans* infections.

The widespread use of broad spectrum antibiotics, parenternal hyperalimentation and aggressive chemotherapy has made it important to recognize the major role of *candida* as a nosocomial pathogen. *Candida* can no longer be thought of solely as a cause of occasional insignificant mucocutaneous infection. *Candida albicans* is a major cause of opportunistic infection and can affect all the organ systems and produce a wide variety of signs and symptoms.

Candida organisms are grouped with the fungi imperfecti (Deuteromyces). There are over 80 species. More than 90% of systemic human infections are caused by *C. albicans,* however, with most of the remainder attributable to *C. topicalis.* These yeasts are part of the normal flora of the skin, female genital tract and gastrointestinal tract. They are also found in urine from catheterized bladders.[1]

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC, National Academy of Sciences, 1980, p. 13.

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Access to the circulation and tissue is available through several routes. Ascending urinary tract infection may occur with indwelling bladder catheters.[2] Direct venous seeding can result from contaminated intravascular catheters. Aspiration has been implicated in lung infections. One investigator demonstrated penetration of normal gastrointestinal mucosa (his own) following the ingestion of 10^{12} *candida* organisms. The virulence of the organism is believed to be related to the transformation of the yeast to the mycelial form within the tissue. It has been suggested that this transformation renders the organism less susceptible to phagocytosis.[1]

Pulmonary

Candidal pneumonia is relatively uncommon, and occurs almost exclusively in infants, the elderly or chronically debilitated individuals. Patients with leukemia and lymphoma appear particularly susceptible to candidal pneumonias.[3]

Dubois, *et al* attempted to classify these patients according to the potential route of infection; endobronchial and hematogenous. Endobronchial candidiasis tended to occur as a result of direct extension of tracheal and laryngeal infection. Lung involvement was usually focal and there was a conspicuous absence of extrapulmonary infection. Hematogenous infection was associated with bilateral, randomly distributed macroscopic hemorrhagic nodules. Multiorgan involvement was common.[4]

Unfortunately, with both routes of infection no characteristic radiographic pattern emerged. The lesions produced were often too small for plain radiographic detection and varied appearance could almost always be explained by associated pathology. Associated pathology included accompanying infectious processes, complications of the primary disease entity and therapeutic interventions.[4]

Esophagus

Candida albicans is normally recovered from mouth washings and stool specimens. Esophageal invasion is thought to stem from immunologic imbalance which allows overgrowth of the yeast.[5] Clinical symptoms include: odynophagia, substernal chest pain, dysphagia, and gastrointestinal bleeding. It may also be entirely asymptomatic.[5]

Radiographically, the distal ⅔ of the esophagus tends to be involved. Early infection appears as a "cobblestone" epithelium, felt to represent submucosal edema. As the disease progresses the lumen becomes shaggy and narrowed. This may then be followed by pseudomembrane formation.[6] Complications include stricture and widespread dissemination. Typically the affected esophagus is atonic and

there is impaired peristalsis.[5,6] Herpes esophagitis often causes an identical appearance on esophograms.

Kidneys and Urinary Tract

Renal candidiasis has been reported in three forms which represent different stages of the same disease process. These are acute pyelonephritis, disseminated candidiasis involving several organs including the kidneys and chronic pyelonephritis or hydronephrosis.[7]

Acutely, the kidneys are edematous and appear enlarged with poor nephrograms. They may contain multiple parenchymal abscesses. Renal function is diminished. Papillary necrosis can result from a more prolonged infection. Filling defects in the renal pelvis, ureters, and bladder may be the result of fungus balls. In some cases the masses contain necrotic papillae. The late roentgenographic appearance is that of chronic pyelonephritis and hydronephrosis.[7,8] Renal infection may lead to widespread hematogenous dissemination.

Bones

Candidal osteomyelitis is a rare infection. It usually occurs as a result of hematogenous seeding or by direct extension from an overlying soft tissue abscess. In adults the most frequent area of involvement is the spine, whereas in children the appendicular skeleton is more commonly effected.[9]

The clinical and radiographic appearance is indistinguishable from bacterial osteomyelitis. The diagnosis is made by radiographic evidence of osteomylitis (bony destruction, regional osteoporosis, soft tissue swelling) followed by culture from needle aspirate or open biopsy.[2]

Treatment

Several drugs are now used to treat candidal infections. Superficial infections are usually well controlled with the use of nystatin, a polyene antibiotic. Amphotericin B is still the mainstay of therapy for parenchymal and disseminated infection. Adverse reactions are a problem. They include renal toxicity, electrolyte imbalance, anaphylaxis, bone marrow depression and gastrointestinal upset. An antimetabolite, 5-fluorocystine, is also useful in treating candidal infection. However, due to the resistance of some candidal strains and the demonstrated synergy with amphotericin B, these drugs are usually used in combination. Major side effects include bone marrow depression and liver toxicity which appear to be reversible. A new imidazole, ketoconazole, has shown promise as a therapeutic alternative in several fungal infections, but its final place in the treatment of candidal infections awaits clarification.[1,10]

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SURGICAL GRAND ROUNDS

(Continued from page 52)

disorders of esophageal physiology, largely due to more widespread use of manometry. ◀

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Board Abstracts

(Continued from page 12)

Other Actions

In reviewing various issues and reports, the Board:

- Authorized the President, Dr. Robert Johnson, to attempt to resolve a problem with the Department of Registration & Education pertaining to delegation of duties in Planned Parenthood facilities, and assigned the matter to the Council on Medical Services for further review and report.
- Approved a breakfast meeting with Illinois physicians attending the new AMA Hospital Medical Staff Section meeting, and a reception for these physicians in the Illinois suite at the conclusion of the Section meeting prior to the AMA Annual Meeting.
- Directed that a one-day ISMS/Specialty Society Forum be developed for October, or late winter, to explore mutual activities and concerns such as legislation, IMPAC, third party payments, loss prevention and ISMS services.
- Accepted for filing the financial statements and reports of March 31.
- Approved replacement of headquarters office print shop equipment.
- Ratified the following eight ISMS-sponsored travel programs for 1984: Virgin Islands air/sea cruise, South Pacific Adventure, Spain/Portugal Adventure, European Adventure, New England air/sea cruise, Russian Adventure, Far East Adventure and Danube River Adventure.
- Approved the schedule of meetings for 1984, as follows:

House of Delegates

April 6-8	Marriott Downtown, Chicago
Nov. 10-11	Clock Tower Inn, Rockford (if called)

Board of Trustees

Jan. 21-22	Marriott O'Hare
April 5-8	Marriott Downtown, Chicago
June 2-3	Arlington Park Hilton
Sept. 15-16	The Hamilton, Itasca
Nov. 9-11	Clock Tower Inn, Rockford

- Authorized publication and distribution of a brochure entitled "The Female Athlete: A Look at the Facts." This will be published in the *Illinois Medical Journal* and be offered, at cost, to physicians' offices.
- Approved, as amended, positions on legislation pending in Springfield as proposed by the Governmental Affairs Council.
- Authorized a meeting with the leadership of the Illinois Dental Society to discuss mutual concerns pertaining to dentists performing histories and physicals on in-hospital dental patients (SB 400).
- Authorized the Council on Education and Manpower to proceed with development of personal learning contracts in a pilot setting to provide an alternative pertaining to mandatory CME.
- Declined participation, at the present time, in a joint program with the Illinois Hospital Association pertaining to coalitions, as this will be part of the presentation at the November Leadership Conference.
- Approved basic guidelines for implementing the Task Force on Financial Aid to Medical Students loan program.

- Received a report on the membership retention project by which Trustees telephoned physicians who were members in 1982 but did not renew in 1983.
- Agreed to nominate a physician for the Illinois Attorney General's Hazardous Waste Task Force.
- Authorized the Publications Committee to set 1984 advertising rates.

Appointments and Nominations

- Drs. Alfred Clementi, Chicago, and Fred Z. White, Chillicothe, were nominated for appointment to a Select Study Committee of the Illinois Senate, reviewing SB 495, the proposed Hospital Revenue Act, which would limit the revenue a hospital could receive based upon a state formula.
- Appointments of ISMS members to one-year terms on the Society's councils and committees for 1983-84 were ratified. Council chairmen appointed: Drs. Raymond A. Dieter, Jr., Glen Ellyn, Affiliate Societies; Fred Z. White, Chillicothe, Economics; Boyd McCracken, Sr., Greenville, Education and Manpower; James Laidlaw, Champaign, Governmental Affairs; Robert Sumner, Harrisburg, Medical-Legal; Joseph D. Winterhalter, Jacksonville, Medical Services; LeRoy Levitt, Chicago, Mental Health and Addiction; Leo Wrona, Joliet, Public Relations. Direct-reporting committee chairmen are: Drs. Cyril C. Wiggishoff, Chicago, Building & Hospital Staffs; Robert Behmer, Rockford, CME Accreditation; Vincent A. Costanzo, Jr., Chicago, Drugs and Therapeutics; Fred Z. White, Chillicothe, Financial Aid to Medical Students; Audley Connor, Jr., Chicago, Health Data Systems; Samuel L. Andelman, Skokie, Health Planning; Allan Goslin, Streator, Health Professions; Lee Gladstone, Chicago, Impaired Physician Panel; William Henry, Springfield, Insurance; Alfred Clementi, Arlington Heights, Loss Prevention Education; Robert C. Hamilton, Chicago, Membership/Marketing; George C. Gertz, Chicago, Peer Review Appeals.
- Nominated to serve on the Illinois Department of Public Aid Full Service Capitation RFP Review Committee: Drs. Paul Lorenz, Carbondale; Charles Frazer, East St. Louis; Arthur Traugott, Urbana; Orlan Pflasterer, Coulterville; Vincent Costanzo, Jr., Chicago; Hugo Velarde, Highland Park; Lorris Bowers, Peoria; James H. Andersen, Oak Brook; Andrew Brislen, Chicago; William Fish, Chicago; Fred Z. White, Chillicothe; James Richardson, Chicago.
- Appointed to a special ad hoc Committee on PROs, to review options available to ISMS, were: Drs. Alfred Clementi (Chairman), Arlington Heights; Robert C. Hamilton, Chicago; Robert P. Johnson, Springfield; Harold Kolb, Champaign; John Ring, Mundelein; Stanley Rousonelos, Joliet; Ronald Welch, Belleville; Fred Z. White, Chillicothe; Cyril C. Wiggishoff, Chicago; Keith Wrage, Rockford; Thomas Meirink, Belleville; David S. Fox, Chicago.
- In response to a request from the Governor, selected for a search committee to recommend nominees for the Director of Mental Health and Developmental Disabilities were: Drs. Arthur Traugott (Chairman), Urbana; David Rothstein, Chicago; Patrick Staunton, Oak Park; LeRoy Levitt, Chicago; Marshall Falk, North Chicago; Henrietta Herbolsheimer, Chicago. A representative of the state Psychiatric Advisory Council also will be included.

Seminars and Programs

- The Board agreed to co-sponsor the 5th Annual Doctors Job Fair with SIU Medical School, Springfield, September 9, 1983.

The next meeting of the Board of Trustees will be September 24-25, 1983, at the Palmer House Hotel, Chicago. ◀

On the Scientific Method And the Deep Tendon Reflex

Every magazine receives letters to the editor. Even critical comments are a welcome sign of healthy dialogue. Most of our letters are published in the Membership Forum column, because most of our readers are ISMS members. This month we introduce a correspondent whose missive gives us a refreshing perspective.

Dear Editor:

I began to write this as a letter of complaint, but now after further thought have changed my drift. I have been receiving copies of the Illinois Medical Journal by error. I am a semiretired realtor and can only blame some gremlin in the post office for my receipt of your magazine. I have, however, read them with such interest that I would prefer not to correct that error so that I may continue my illicit enjoyment. This reading, along with conversation with local physicians in various service clubs to which I belong has caused questions to arise in my mind. I must state that my qualifications for offering the opinions that follow are impeccable. I know nothing about medicine, the profession or its inner workings. In fact I seldom avail myself of the services offered. You see, then, that I have no vested interest and possess total objectivity.

However, as I have read the IMJ and listened to physicians locally, I have been struck with the careful, conservative scientific method utilized by physicians in their practice. The investigation and reporting of rare or different cases is done objectively and with full investigation and discussion of possible causes and methods to be utilized. Drugs and new methods of treatment are discussed and rather conservatively tried before they are either rejected or accepted with more universal application. It seems that there must be several ways of approaching problems and more than one way of dealing with those problems, or at least that is the impression I have gained.

The overall process seems to be: look thoroughly and cautiously at any notion, test it against the standard of practice, utilize that new methodology slowly and carefully and then embrace it only if it has met the test of time. This certainly represents a scientific, judicial, thoughtful and conservative approach to man's ills.

The dichotomy that I have noticed and am at a loss to understand is that physicians seem not to use the same approach when the issue is not medical. If the issue is a social or financial one, the response that I have noticed is more knee jerk (or perhaps deep tendon reflex) than scientific. Concern for broad classifications of society or of segments of society not essentially medical is not as studied or conservative.

Can it be that physicians leave their scientific method in their offices when they look at and discuss other issues? Or perhaps I lack depth of understanding or have not read broadly enough. For that reason I will not complain about receiving the IMJ by mistake and look forward to commenting on subsequent issues and volumes from my purely objective and noninvolved point of view.



Sincerely,
Emerson Goodwins

Editor's Note: A check of our subscription listings determined that we had, indeed, come upon Mr. Goodwins as the result of a clerical error. At press time, however, we had heard from him once again, and determined that the benefit of his perspective could be well worth a subscription. In return, he has pledged to examine our work and offer his point of view. When a second opinion is needed, we promise to keep you posted.

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Doctor's News

PHYSICIANS IN THE NEWS—**Harry A. Springer, M.D.,** Evanston, has been elected president-elect of the Chicago Medical Society. A plastic surgeon, Dr. Springer fills the office left vacant by the February 26 death of John P. Harrod, Jr., M.D. Dr. Springer assumed office as president on June 29. **Harold L. Jensen, M.D.,** Flossmoor, was elected chairman of the CMS Council, the office previously held by Dr. Springer. Dr. Jensen, an internist, was vice-chairman of the council.

Lourdes D. Floro, M.D., Chicago, has been elected to fellowship in the American Academy of Pediatrics.

Recently elected officers at the Illinois Masonic Medical Center are: **Joseph H. Robbins, M.D.,** president and **Hilde Osto, M.D.,** president-elect, both of Chicago; and **Richard A. Bloom, M.D.** of Cicero, secretary-treasurer.

Edward A. Litcher, M.D. of Evanston has been elected to a three-year term on the board of directors of the Association of Teachers of Preventive Medicine.

Arnold Swerdlow, M.D. of Skokie has been elected president of the medical staff of Skokie Valley Hospital.

Recently elected officers of the South Chicago Community Hospital are: **Lester H. Davis, M.D.** of Chicago, president; **Virendra Bisla, M.D.,** president-elect, Flossmoor and **Antonio Gutierrez, M.D.,** medical staff secretary, Chicago.

IMPAIRED PHYSICIAN COMMITTEE HANDBOOK NOW AVAILABLE—"Guidelines for Hospital Committees to Assist Impaired Physicians" is now available from the Illinois State Medical Society. The handbook contains information on the impaired physician committee, dealing with the impaired physician, legal issues and descriptions of programs in other states. The ISMS committee for the impaired physician was established in 1976 to assist any physician whose ability to practice medicine is impaired by alcoholism, drug abuse, physical or emotional problems.

WORKER'S COMPENSATION PAYROLL AUDITS—Persons covered by worker's compensation policies with Casualty Reciprocal Exchange may be called upon by field payroll auditors. Advance preparation of records for the audit can expedite distribution of earned savings by the Dodson Insurance Group. If asked to provide a voluntary report instead, payment of savings can be expedited if requested information is quickly returned.

DRUG ABUSE INSTITUTE—The fourth annual Illinois Institute on Drug Abuse will be held August 1-4 at the Illinois Wesleyan University, Bloomington. For further information contact Louis DiFonso, Illinois Dangerous Drugs Commission, 300 North State St., Suite 1500, Chicago, IL 60610.

NATIONWIDE ORGAN DONOR HOTLINE—The nation's first toll-free telephone number for physicians, nurses and other health professionals with questions about potential organ donation has been established at the University of Pittsburgh.

The 24 hour-a-day number is 800-24-DONOR. Use of the service is restricted to doctors, nurses and other health professionals.

The new number, a service of the North American Transplant Coordinators Organization (NATCO), provides information on organ needs of the major transplant institutions in the United States and Canada.

PATIENTS SOUGHT FOR CARDIOVASCULAR DISEASE RESEARCH—The department of psychiatry at Rush Presbyterian-St. Luke's Medical Center, in collaboration with the section of cardiology, is seeking referral patients in its investigation of the use of antidepressants in cardiovascular disease.

Hospitalized, depressed patients with hypertension, congestive heart failure, arrhythmias or cardiac conduction disturbances are treated with maprotiline, doxepin or desipramine and are monitored carefully with electrocardiograms, Holter monitors, echocardiograms and plasma level determinations. There is no cost to the patient for the consultations or procedures, but patients must have funding for the hospitalization.

Referrals may be submitted by telephone to Drs. Robert Wettstein or Stephanie Cavanaugh at (312) 942-5015.

SPECIALTY STATISTICS—AMA Physician Masterfile records indicate that primary care physicians numbered 192,583 in 1981, representing 44% of practicing physicians. A breakdown of primary care specialties follows: internal medicine, 17.5%; family practice, 7.2%; pediatrics, 6.9%; general practice, 6.8% and obstetrics/gynecology, 6.3%.

Percentages of the 288,038 office-based physicians were: 17.3% in general practice; 28.5% in medical specialties; 29.9% in surgical specialties and 24.3% in other direct patient care activities.

In 1981, 15,542 resident physicians specialized in internal medicine while 8,272 specialized in general surgery and 5,316 specialized in family practice.

SEXUALLY TRANSMITTED DISEASE COURSES—Physicians, nurses and other clinical personnel are invited to attend courses on sexually transmitted diseases offered by the Chicago Department of Health in conjunction with the University of Illinois Medical School and the federal centers for disease control.

The STD Training Center offers three separate courses to be held throughout 1983. They are: a two-week introductory class, a one-week intensive class and a two-day update for clinicians.

For more information contact Louise Galaska, STD Training Center, 27 E. 26th St., Chicago, IL 60616 or call (312) 225-9598.

CANCER CARE SEMINAR—The Third National Seminar on Community Cancer Care will be held September 16-18 at the Hyatt Regency, Indianapolis, Indiana. The purpose of the seminar is to encourage and give direction to the development of community initiated cancer care programs. For details of the seminar write to: Office of Continuing Medical Education, Methodist Hospital of Indiana, Inc., 1604 N. Capitol Ave., Indianapolis, IN 46202.

MERRELL DOW ENDS BENDECTIN PRODUCTION—Merrell Dow Pharmaceuticals has ceased production of Bendectin, the only U.S. approved drug for relief of nausea and vomiting of pregnancy. Dow took this action reluctantly, due to adverse publicity and litigation about the drug, according to a recent news release. Dow notes that Bendectin has been tested extensively and used safely for 27 years and that clinical and epidemiological studies demonstrate the safety of the product. According to Dow's president, David G. Sharrock, women presently taking Bendectin should not be alarmed by this action, which was based solely on non-medical factors. The company is attempting to maintain supplies in the marketplace to fill the needs of patients currently completing therapy.

Staff physicians are available to consult on specific inquiries. Questions and additional information can be obtained by contacting Merrell Dow Pharmaceuticals at 800-543-1970, (in Ohio 800-582-3109).

OPPORTUNITY GUIDES NOW BI-MONTHY—AMA has announced that their Opportunity Placement Register (OPR) and Physician Placement Register (PPR) will now be published bi-monthy by the Physicians' Placement Service (PPS). PPS was formed by the AMA to help young physicians find positions. The OPR lists practice opportunities indexed by state and specialty and is sent to physicians seeking jobs. The PPR, indexed by specialty and type of practice sought, is sent to opportunity contacts. The registers are provided to state medical associations, medical school libraries, medical school deans, state and federal government organizations, county medical societies and medical specialty societies.

"LOOK-ALIKE DRUGS"—The AMA has adopted a firm policy in opposition to the manufacture, sale and distribution of "look-alike drugs." These drugs mimic the size, shape, and color of controlled substances such as amphetamines or tranquilizers. Yet they usually contain caffeine, phenylpropanolamine, caffeine and ephedrine combined, or antihistimines.

"Look-alike drugs" can be harmful, especially when taken with alcohol, as many teenagers do. Physicians and poison centers can be deceived by the fake drugs. Additional background information on "look-alike drugs" is available from the AMA, 535 N. Dearborn St., Chicago 60610.

RABIES OUTBREAK—Public health officials have warned of a rabies outbreak among domestic animals in Chicago. A recent Chicago Medical Society news release urges persons bitten by an animal that may have rabies to seek medical treatment immediately.

The Chicago Department of Health, Cook County Department of Public Health and CMS have issued a joint alert to Cook County physicians to consider the possibility of rabies when treating wounds inflicted by domestic animals as well as stray animals.

LICENSING POLICY PUBLICATION—An AMA publication titled "U.S. Medical Licensure Statistics 1980-81 and Licensing Requirements of 1982" explains current licensing policies of state boards. The publication, intended for physicians setting up their first practice or relocating a practice, contains information on initial licensure for U.S. and foreign graduates, reciprocity and endorsement, fees and renewal intervals, and National Board and ECFMG requirements. The 37-page booklet also contains data on the number of licenses issued in a variety of categories.

Physicians may obtain a free copy of the licensing booklet from the Division of Survey and Data Resources, Department of Data Planning and Evaluation, AMA headquarters, 535 N. Dearborn, Chicago, IL 60610.

NATIONAL SAFETY CONGRESS—The National Safety Council will hold its 71st annual congress in Chicago, October 17-20. The international event will draw thousands of safety professionals, including medical specialists. For more information write to Congress Planning, National Safety Council, 444 N. Michigan Ave., Chicago, IL 60611 or call (312) 527-4800.

ACP PROMOTES JOINT EFFORT IN DEVELOPMENT OF ORPHAN DRUGS—The American College of Physicians believes that the pharmaceutical industry, federal government and physicians should make a joint effort in orphan drug development, according to a recent news release.

The College points out that the pharmaceutical industry may not be financially capable of developing large numbers of commercially unprofitable drugs but can still continue to sponsor orphan drug development. Physicians can participate in basic and applied research necessary for development of orphan drugs.

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Eleventh Annual Congress/CME

CME Goals, Objectives and Evaluation

The Critical Link

October 14-15, 1983, at the Drake Oakbrook Hotel

West 22nd Street at York Road, Oak Brook, Illinois

The major emphasis of the 1983 Congress is to provide direction in the development and implementation of appropriate goals, objectives and evaluation techniques in offering effective CME programs to respond to physicians' learning needs.

The Congress will take place from Friday morning, October 14 to Saturday afternoon, October 15. You are offered a wide variety of small group workshops, as well as the opportunity for individual consultations with CME experts. These are arranged to assist CME planners who attend the Congress with specific planning problems.

"What is the Future of CME?" is the topic of debate to be presented by the distinguished keynote speakers: Gerald Escovitz, M.D., vice dean, The Medical College of Pennsylvania; Jacob Suker, M.D., associate dean of graduate education, Northwestern University Medical School and William Ruhe, M.D., former vice president, scientific activities, American Medical Association. The future of CME will be addressed from three separate perspectives, including CME sponsors, accreditation and organized medicine.

The small group workshops this year will include such topics as computer assisted instruction and the application of microcomputers to CME, problem based learning modules and the opportunities and limitations of evaluation in CME. Other topics include methods of delivering CME from lectures to advanced communications and use of malpractice data in developing goals and objectives.

Three additional workshops are specifically designed for the non-physician medical educator and administrative support staff.

For additional information, write or call the Illinois Council/CME, 55 East Monroe, Suite 3510, Chicago, Illinois 60603, (312) 236-6110. ◀

Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

AUGUST

Emergency Medicine

Specialty Review in Emergency Medicine
For: ER Physicians. Lecture, August 1-6, Chicago. **Speaker:** Jomes Mothews, IV, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $425. **Credit:** Cotegory 1, 47 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Medicine

Specialty Review in Internal Medicine/Certifying
For: Internists, Medicol Subspeciolists. Lecture, August 7-13, Chicago. **Speaker:** Sheldon Woldstein, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Cotegory 1, 72 hours. **Contact:** Robert 8oker, MD. **Phone:** 312/733-2800.

Pediatrics

Specialty Review in Neonotology/Perinotology
For: Pediotricions, Obstetricions. Lecture, August 29-Sept. 2, Chicago. **Speoker:** Dhormopuri Vidyosogor, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Cotegory 1, 50 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Sports Medicine

Sports Medicine Seminar
For: MD's. Lecture, August 15, Chompoign. **Sponsor:** Corle Foundotion Hospitol, 602 W. University Ave., Urbono 61801. **Reg. deodline:** 8/5. **Fee:** $25. **Credit:** Cotegory 1, 2.5 hours; AAFP Elective, 2.5 hours. **Contoct:** Edword Grogg, MD. **Phone:** 217/337-3342.

Surgery

Specialty Review in General Surgery, Port II
For: Generol & Speciolizing Surgeons. Lecture, August 15-26, Chicago. **Speoker:** Robert 8oker, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $600. **Credit:** Cotegory 1, 100 hours. **Contact:** Robert Boker. **Phone:** 312/733-2800.

Surgery

Fiberoptic Colonoscopy
For: Surgeons, Internists, Gostroenterologists. Lecture, August 24-26, Chicogo. **Speoker:** Herond Abcorion, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 20. **Credit:** Cotegory 1, 15 hours. **Contoct:** Robert Boker, MD. **Phone:** 312/733-2800.

Surgery

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gostroenterologists. Lecture, August 29-31, Chicogo. **Speaker:** C. Thomos Bombeck, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 15. **Credit:** Cotegory 1, 16 hours. **Contoct:** Robert Boker, MD. **Phone:** 312/733-2800.

SEPTEMBER

Dermatalagy

Specialty Review in Dermotology
For: Dermotologists. Lecture, Sept. 26-30, Chicogo. **Speoker:** Morshall Blonkenship, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $390. **Reg. limit:** 90. **Credit:** Cotegory 1, 34 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Immunalagy

Follow-Up in Immunology
For: MD's. Symposium, Sept. 7, 8:30 o.m., Woukegon. **Speoker** Allen Luskin, MD. **Sponsor:** Victory Memoriol Hospitol, 1324 N. Sheridon Rd., Woukegon 60085. **Fee:** $10; $15, non-stoff. **Reg. limit:** none. **Credit:** Cotegory 1, 3 hours; AAFP Elective, 3 hours. **Contoct:** Moureen Bortholomew. **Phone:** 312/578-4006.

Internal Medicine

Specialty Review in Medicol Oncology
For: Internists, Oncologists. Lecture, Sept. 19-23, Chicogo. **Speoker:** John Merrill, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood, Chicogo 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Cotegory 1, 40 hours. **Contoct:** Robert Boker, MD. **Phone:** 312/733-2800.

Internal Medicine

Specialty Review in Gostroenterology
For: Internists, Gostroenterologists. Lecture, Sept. 19-23, Chicogo. **Speoker:** Ruven Leviton, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Credit:** Cotegory 1, 40 hours. **Contoct:** Robert Boker, MD. **Phone:** 312/733-2800.

Internal Medicine

Specialty Review in Endocrinology & Metobolism
For: Internists, Endocrinologists. Lecture, Sept. 19-23, Chicogo. **Speoker:** Sheldon Woldstein, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Cotegory 1, 40 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Neuralagy

Diagnosis ond Monagement of Neuropathies
For: MD's. Symposium, Sept. 23-24, Modison, WI. **Sponsor:** U of Wisconsin—Extension, 4658 WARF Bldg., 610 Wolnut St., Modison, WI 53705. **Fee:** $160. **Reg. limit:** none. **Credit:** Cotegory 1, 11 hours; AAFP Elective, 11 hours; AOA, 11 hours. **Contoct:** Soroh Aslokson. **Phone:** 608/263-2856.

Pathalagy

Specialty Review in Pathology: Anotomic
For: Pothologists. Lecture, Sept. 26-Oct. 1, Chicogo. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $480. **Reg. limit:** 90. **Credit:** Cotegory 1, 48 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview
For: Psychiotrists. Course, Sept. 30-Oct. 2, Chicogo. **Sponsor:** The University of Chicogo, 950 E. 59th St., Box 139, Chicogo 60637. **Fee:** $325. **Reg. limit:** none. **Credit:** Cotegory 1, 20 hours. **Contact:** Mory Ann Dillon. **Phone:** 312/962-1056.

Spinal Card Injury

Monogement of the Spinol Cord Injured Patient
For: MD's. Course, Sept. 12-14, Chicogo. **Sponsor:** Rehobilitotion Institute of Chicogo/Northwestern University, 345 E. Superior St., Chicogo 60611. **Reg. deadline:** 9/1.**Fee:** $200; $125, resident. **Reg. limit:** 110. **Credit:** Cotegory 1, 17 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

Spinal Cord Injury

Frontiers in Spinol Cord Regenerotion
For: MD's. Course, Sept. 15-16, Chicogo. **Sponsor:** Rehobilitotion Institute of Chicogo/Northwestern University, 345 E. Superior St., Chicogo 60611. **Reg. deadline:** 9/4. **Fee:** $250; $125, resident. **Reg. limit:** 110. **Credit:** Cotegory 1, 14 hours. **Contoct:** Don Olson, PhD. **Phone:** 312/649-6179.

Mark Your Calendar Now!

11th Annual Congress on CME
October 14-15, 1983
The Drake Oakbrook/Oak Brook, IL

CME Goals, Objectives and Evaluation: The Critical Link

Brochures available after July 1 from
ICCME, 55 E. Monroe St., #3510, Chicago, IL 60603

OCTOBER

Cardiology

Electraphysiologic Basis for Diagnasis and Management of Cardiac Arrhythmias
For: MD's. Conference, Oct. 6-8, Milwaukee, WI. **Sponsar:** U of Wisconsin—Extension, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 18 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Cardiopulmonary Medicine

Scientific Assembly
For: MD's. Conference, Oct. 23-27, Hyatt Regency Hotel/Illinois Center, Chicago. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30+. **Contact:** Dole Braddy. **Phone:** 312/698-2200.

Critical Care

Critical Care Medicine
For: Anesthesiologists, Internists, Pediatricians, Surgeons. Lecture, Oct. 24-28, Chicago. **Speaker:** Dharmapuri Vidyasogar, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Internal Medicine

Hepatic Diseases
For: MD's, Surgeons. Symposium, Oct. 11, 7:00 p.m., Vandalia. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Internal Medicine

Chest Poin Syndromes
For: Internists. Symposium, Oct. 20-22, Chicago. **Sponsar:** Center for Poin Studies, Rehabilitation Institute of Chicago; Northwestern University Medical School, 345 E. Superior, Chicago 60611. **Fee:** $240; $150, residents. **Reg. limit:** 250. **Credit:** Category 1, 17 hours. **Contact:** Elly Henig. **Phone:** 312/649-6190.

Internal Medicine

Genetics of Diabetes and the Insulin Gene
For: MD's. Symposium, Oct. 5, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $50. **Reg. limit:** 150. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours; AOA, 6 hours. **Contact:** Loretta Giocoletto. **Phone:** 314/367-9673.

Internal Medicine

Specialty Review in Cardiovasculor Disease
For: Internists, Cardiovasculor Specialists. Lecture, Oct. 10-14, Chicago. **Speaker:** John Demakis, MD. **Sponsar:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Neurology

Contemporary Topics in Neurology
For: Neurologists, Psychiotrists, Neurosurgeons. Lecture, Oct. 17-21, Chicago. **Speakers:** Frank Rubino, MD; Sandra Olson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $420. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Nuclear Cardiology

Nucleor Cardialogy Symposium
For: MD's. Symposium, Oct. 12-15, Milwaukee, WI. **Sponsar:** U of Wisconsin—Extension, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 23 hours. **Contact:** Sorah Aslokson. **Phone:** 608/263-2856.

Ob/Gyn

Specialty Review in Obstetrics & Gynecology
For: Obstetricions, Gynecologists. Lecture, Oct. 17-22, Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsar:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathology

Specialty Review in Pathalogy: Clinicol
For: Pathologists. Lecture, October 3-7, Chicago. **Speaker:** Alvin Ring, MD. **Spansar:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Psychiatry

Psychiotry Updote
For: Surgeons, MD's. Symposium, Oct. 28, Springfield. **Sponsar:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Psychiatry

The Many Faces of Depression
For: MD's. Course, Oct. 21, Springfield. **Sponsar:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Cantact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Psychiatry

Contemporary Topics in Psychiotry
For: Psychiatrists. Lecture, Oct. 10-14, Chicago. **Speaker:** Francois Alouf, MD. **Spansar:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $420. **Reg. limit:** 90. **Credit:** Category 1, 42 hours. **Cantact:** Robert Baker, MD. **Phone:** 312/733-2800.

Radiology

Radiologic Diagnosis and Monagement of Acute Diseose and Trauma
For: Radiologists, ER Physicians, Surgeons. Conference, Oct. 19-22, Madison, WI. **Spansar:** U of Wisconsin—Extension, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $375; $150, residents. **Reg. limit:** none. **Credit:** Category 1, 25 hours; ACR, 25 hours applied for. **Cantact:** Sarah Aslakson. **Phone:** 608/263-2856.

Suicide Intervention

Suicide Assessment and Intervention
For: Health Professionals. Workshop, Oct. 12, Madison, WI. **Speaker:** Bernadine Bednarz, MSW. **Sponsor:** U of Wisconsin—Extension, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $55. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Cantact:** Sarah Aslakson. **Phone:** 608/263-2856.

Sports Science

Health and Sports Science Sympasium
For: MD's. Symposium, Oct. 19-22, Civic Center, La Crosse, WI. **Spansar:** La Crosse Exercise Progrom, 221 Mitchell Hall, University of Wisconsin, La Crosse, WI 54601. **Reg. deadline:** none. **Fee:** $225. **Reg. limit:** none. **Credit:** Category 1, 24 hours. **Contact:** Philip Wilson. **Phone:** 608/785-8686.

Surgery

Specialty Review in General Surgery, Part I
For: General and Speciolizing Surgeons. Lecture, Oct. 3-14, Chicago. **Speaker:** Robert Baker, MD. **Spansar:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Credit:** Category 1, 98 hours. **Cantact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Fiberaptic Colonascapy
For: Surgeons, Internists, Gastroenterologists. Lecture, Oct. 5-7, Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Fiberoptic Esophogogostric Endascapy
For: Surgeons, Internists, Gastroenterologists. Lecture, Oct. 10-12, Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Cantact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Specialty Review in Peripheral Vascular Surgery
For: Peripheral Vascular Surgeons. Lecture, Oct. 31-Nov. 4, Chicago. **Speaker:** D. Preston Flanigan, MD. **Spansar:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Independent Study

The University of Wisconsin offers a number of courses for primary care physicians that enable you to continue learning in the privacy of your home or office, studying at your convenience. Available are:

Drugs and the Central Nervous System
Immunodeficiency Diseases
Hypertension
Basic Pharmacology
Basic Hematology

Each course carries Category 1 credit, ranging from 20-45 hours. Each is updated regularly.

For complete details, write or call:

Richard H. Hansen
University of Wisconsin
Home Study—CME
460 WARF Bldg., 610 Walnut St.
Madison, WI 53706
(608) 263-2853

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Family Practitioner. Excellent practice opportunity. Join young group of board-certified internists, family practitioners providing comprehensive health care in beautiful, wooded southern Illinois. Office adjacent to community hospital. Major state university (20 miles away), with medical school offers opportunity for affiliation. Administrative support provided. Guaranteed salary, bonus, fringes. Contact Susan Casey, Rural Health, Inc., 517 North Main Street, Anna, 62906 (618-833-4471). (8)

CAIRO: Seeking Emergency Medicine, Internist, and/or Family Practitioner to join multi-specialty medical group serving two-county area (pop. 20,000). Sixty miles south of Carbondale. Complete office facilities available with financial assistance. Outdoor recreation abundant. Contact: Steve Miller, Director, 529 Cross Street, Cairo 62914 (618-734-4200). (8)

DYER, IN: Two board certified/eligible psychiatrists to establish practice in our service area: (1) Private practice with contractual arrangement in substance abuse program and (2) adult private practice with minimal guarantee until practice is established. Contact: Professional Recruiter, Our Lady of Mercy Hospital, U.S. Hwy. 30, Dyer, Indiana 46311 (219) 865-2141 (8)

FAMILY PHYSICIAN: University clinics, the Chicago Medical School. Board certified specialist in family medicine for full-time ambulatory clinical practice. Faculty appointment, medical administrative responsibilities, work closely with clinics administrator. Substantial benefits package, malpractice insurance paid. Send C.V. to: T.M. Robertson, Clinics Administrator, University Clinics, 3333 Green Bay Road, North Chicago, 60064, or telephone (312) 578-3244. (10)

GIBSON CITY: Cardiologist, internist wanted to join expanding multi-specialty medical staff associated with modern well equipped hospital; ICU capable of invasive monitoring; attached privately funded SNF; new professional office space available; rural community in east central Illinois within 30 minutes of major universities, tertiary care centers, metropolitan areas with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City, 60936 (217/784-4251). (7)

Classified Advertising

All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of $2 will be assessed when a box number is requested.

CLASSIFIED ADVERTISING RATES

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	$6.00	$9.00	$14.00	$20.00
3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

POSITIONS AND PRACTICE

FAMILY PRACTITIONER/INTERNAL MEDICINE—To locate in Rosiclare, Illinois. 49-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forrest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare, IL. 62982. (618) 285-6634.

ILLINOIS, CHICAGO: EXPERIENCED EMERGENCY PHYSICIANS needed for progressive community hospital. Excellent salary and benefits. Good specialty backup. Send resume to One E. Wacker Dr., Suite 2222, Chicago, IL 60601 or call (312) 661-1457.

CHICAGO AREA MEDICAL CENTER is in the process of building 5 community-oriented satellite facilities to include urgent care, specialty offices, and community education facilities. Emphasis on teaching of health awareness, health education, and stress management to citizenry, in addition to outpatient family practice type of setting. Qualified applicants should have experience in family practice or other primary care field, preferrably board certified, and should have an interest in health education. Please send CV in confidence to One East Wacker Dr., Suite 2222, Chicago, IL 60601, or call (312) 661-1457.

EMERGENCY MEDICINE: PART-TIME AND FULL-TIME positions available in over 20 emergency departments located in central and southern Illinois. Earn a competitive income while enjoying the many challenges emergency medicine offers. Flexible scheduling and paid professional liability insurance provided. For complete details write or call Catherine Offut, Spectrum Emergency Care, Inc., 999 Executive Parkway, P.O. Box 27352, St. Louis, MO 63141; 1-800-325-3982.

EXCELLENT OPPORTUNITY in Northwest suburbs for child psychiatrist working part time or full time in private group practice involving inpatient and outpatient adolescent, child and adult care. Must have inpatient adolescent experience and board eligibility. Please send vitae to Box #1076 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

ASSISTANT DIRECTOR—4 y/o approved community based family practice residency affiliated with Southern Illinois University. Generous salary and fringes for M.D. (board certification highly desirable). Assistant professor or higher rank depending upon background. Administration, teaching and practice responsibilities. Applications accepted until position filled. Reply to: David Ouchterlony, M.D., Director, Decatur Family Practice Center, 1314 N. Main, Suite 201, Decatur, IL 62526 (217) 423-8186. S.I.U. School of Medicine is an Equal Opportunity/Affirmative Action Employer.

OTOLARYNGOLOGIST—Excellent opportunity for full or part-time combined practice with ophthalmologist located SW of Chicago. Tuesday and Friday office hours advisable with Thursday surgical day. Write Box 1051 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

OPHTHALMOLOGY/LOCUM TENENS or association—Opportunity for surgical assisting, office, glaucoma management, refraction and eye care located SW of Chicago. Write to Box #1051 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

FULL TIME PHYSICIAN FACULTY POSITION—Innovative and expanding family practice residency affiliated with Southern Illinois University. Board certification with two years post-residency experience and family practice experience with obstetric capabilities required. Assistant Professor. Teaching, patient-care, administrative and research opportunities. Generous salary and fringe benefit plan. Closing date: June 1, 1983 or until filled. Reply to: J. Paul Newell, M.D., Director, Belleville Family Practice Residency Program, 300 West Lincoln Street, Belleville, IL 62220. (618) 233-5480. SIU School of Medicine is an Equal Opportunity/Affirmative Action Employer.

INTERNIST W/WO SUBSPECIALTY: To join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, IL. 61032.

OBSTETRICIAN/GYNECOLOGIST: To join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

WELL ESTABLISHED SURGEON (F.A.C.S., F.I.C.S.) retiring. Surgical practice for sale or lease, with option to buy building. Exceptional opportunity in outstanding community. Excellent medical staff, 349 bed hospital. Reply in confidence to: Box #1047, Columbus, In. 47201.

FAMILY PRACTITIONER, OBSTETRICIAN-GYNECOLOGIST, GENERAL INTERNIST needed to staff Carle Clinic—Danville Satellite. Satellite physicians are part of a large multi-specialty clinic group which provides financial, administrative, educational and medical specialty support. Liberal fringe benefits include adequate time off for educational meetings and vacation. University teaching opportunities available. Write including CV to John W. Pollard, M.D., Executive Vice-Chairman, Carle Clinic, Urbana, Illinois 61801.

NEUROLOGIST, PSYCHIATRIST, ORTHOPEDIST, AND INTERNIST needed, (Board Eligible or Board Certified), for part-time diagnostic outpatient work-ups in Beloit, Wisconsin. No calls, no weekends, or long term treatment involved. Flexible hours. Send CV to Personnel, Box 8320, Chicago, Illinois 60680.

FAMILY PRACTITIONER—Exceptional opportunity to take over profitable practice in central Illinois community near Springfield: will remain to introduce. Fully-accredited 60-bed hospital in town. Write Box 1082, c/o Illinois Medical Journal, 55 East Monroe, Suite 3510, Chicago, Illinois 60603.

ANESTHESIOLOGIST retired, looking for part-time or locum tenens for anesthesia coverage anywhere in Illinois; anytime. Call (312) 361-1848.

CARDIOLOGIST: Partnership opportunity in community located on Lake Michigan between Chicago and Milwaukee. Noninvasive and clinical emphasis. Excellent medical facilities. Guaranteed salary, complete benefits. Senior partner retiring. Contact Phillip Kelbe, Fox Hill Associates, 260 Regency Court, Waukesha, WI 53186, (414) 785-6500 (no fees).

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CHICAGO: EXPERIENCED GENERAL PRACTITIONER wanted for Urgent Care Clinics in new southwest suburban Chicago areas. Regular hours, no night call. Minimum guarantee with capitation or fee-for-service. Call or send CV to Dr. Wadley at P.O. Box 356, Winnetka, IL 60093, (312) 441-7162.

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GENERAL PRACTICE FOR SALE—Excellent western suburban location. Close to two community hospitals. Well equipped, two exam rooms and a consultation room. Located next door to pharmacy. Call (312) 231-1121.

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FAMILY PHYSICIANS—Unique opportunity for BC/BE family practice physician to join prepaid group practice in Kansas City. To staff and develop a family practice facility 15 minutes from established multi-specialty group practice. Facility will include laboratory, X-ray and pharmacy. Attractive salary structure and liberal fringes. Starting salary based on experience. Recruitment and relocation expenses covered. Send CV to Michael R. Soper, M.D., 6801 E. 117th St. Kansas City, MO 64134, or call (816)765-6200.

WANTED—ILLINOIS LICENSED PHYSICIANS to perform insurance physicals. Also ECG. Full or part time on a mobile basis. Please call (312) 763-8744.

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OBSTETRICIAN/GYNECOLOGIST: To join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 S. Kiwanis Dr., Freeport, IL 61032.

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ASSOCIATE OPHTHALMOLOGIST desired, part time, Elgin area. One day per week. Write to Box #1089 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

THREE TO FOUR FAMILY PRACTITIONERS needed to staff three satellites of a 34 physician multispecialty group in beautiful small east-central Wisconsin communities. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R. B. Windsor, M.D., 1101 8 St., Sheboygan, WI 53081 phone (414) 457-4461.

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MATURE PHYSICIAN with strong internal medicine and pulmonary background seeks primary care practice in rural midwest. Write to Box #1085 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

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President's Page

One Facet—A Year Later



Medical Discipline

In the August, 1982, issue of the *Illinois Medical Journal* then President Cyril C. Wiggishoff shared with you in an interview his responses to many facets of policing the profession and we published an ISMS position paper on medical discipline. During this first half of 1983, a physician from Springfield, John V. Standard, M.D., accepted the assignment of medical coordinator for the Medical Disciplinary Board.

Dr. Standard has been in the practice of medicine for over 25 years in his community in the discipline of obstetrics and gynecology. He has been noted for his firm conviction that a self-policing medical profession is a healthy medical profession. I would like to use my President's Page this month to introduce him to you, the membership, through his response to several questions regarding his initial exposure to the task he has been asked to accept with the Medical Disciplinary Board.

Dr. Johnson: As you became oriented to your position with the Department of Registration and Education, serving the Medical Disciplinary Board as its medical coordinator, what were your impressions of the history of this unit of the Department?

Dr. Standard: The present Medical Disciplinary Board deserves a sustained thanks for their dedicated performance during the past years. Until two years ago, the Board was forced to operate under a climate that appeared to have been one of calculated neglect of the Board's presence. And, until recently, the medical investigative personnel quality and quantity was less than sufficient. These deficient conditions have been substantially corrected.

Dr. Johnson: What strategy has been developed to enhance the investigative phase of the complaints received by the Medical Disciplinary Board?

Dr. Standard: I feel that the following three actions have been implemented to motivate change toward improved process for the work of the MDB.

1. Quantity and quality of medical investigative personnel within the Department has been improved immeasurably.
2. Strict protocol mapping of complaint from receipt to disposition has been imposed. Each receives accurate medical investigative attention, then medical coordinator review and judgment, next complaint committee repeat review and judgment followed by regulatory (legal) division acceptance. Finally, the case is presented to the Medical Disciplinary Board for final review, judgment and discipline determination by the Medical Disciplinary Board.
3. Avowed and demonstrated support by the director of the Department of Registration and Education that the rules governing the enactment of the Medical Practice Act and now the Mandatory Reporting Act will be enforced in concert with the Medical Disciplinary Board responsibilities and an open door policy of welcoming input from any individual or group delivering medical care.

Dr. Johnson: What impact do you see resulting from the Mandatory Reporting Act?

Dr. Standard: The impact of mandatory reporting on the Department of Registration and Education and the Medical Disciplinary Board is yet to be known. Just now the forms necessary for reporting are going to the various bodies mandated to report. There is a prevalent opinion that once in gear, the demand on the Department personnel and the Medical Disciplinary Board will multiply.

Dr. Johnson: Can the organizations of medicine, such as county medical society, hospital medical staff and regional peer review organizations be a factor in the quantity of work you perceive will fall to the Medical Disciplinary Board with mandatory reporting?

Dr. Standard: The load will be inversely proportional to the level of local peer review in the organizations of medicine you have named. Traditional peer review, if ignored locally, will more and more be shifted to the state level as the public learns of this avenue of legal redress. Many of the complaints now reaching the state would have been short-stopped by the local level if proper peer review function was ongoing. Further, local peer review identifies general and usual patterns of performance that are more useful in altering physician behavior and serve in a preventive mode not available to the Medical Disciplinary Board. Their action is in regard to a complaint that in many instances calls upon them to judge competence from a single medical act. I have no fear that the Board will make these difficult judgments but a stronger preventative system would reduce their load.

This brings to you, our readers, a brief picture of one facet of the ongoing work to fulfill our responsibility to police the profession. ◂



Robert P. Johnson, M.D., President

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

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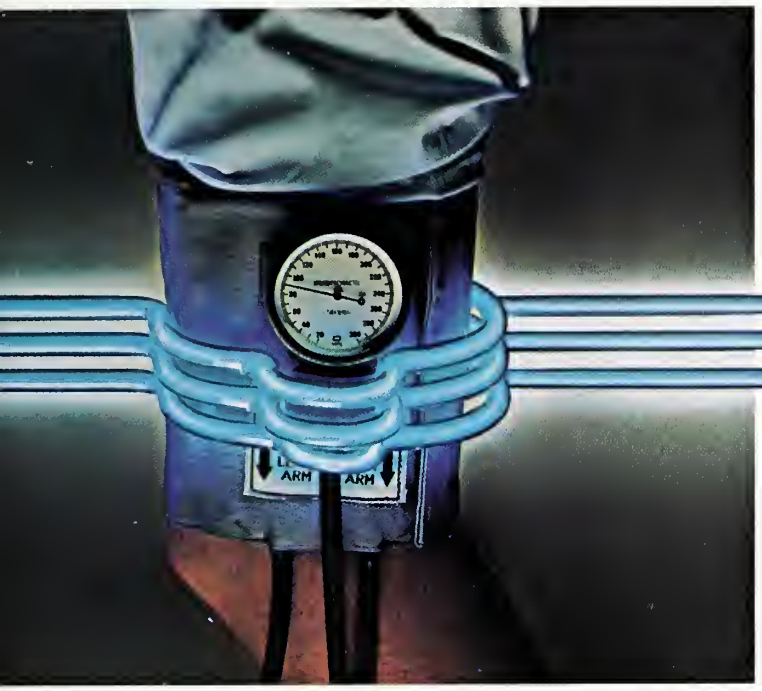
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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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New York, N.Y. 10017

A Second Opinion

Last month we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Who Picks Up the Tab?

Dear Editor;

On Monday last, at the regular meeting of the 10 o'clock coffee break round table, there was a discussion, which upon reflection, I thought would be of interest to your readers. For the content of that discussion was similar to some reading I have done in the *IMJ* and other assorted, misdirected, but appreciated mailings from ISMS.

The 10 o'clock CBRT meets nearest the window at the Apollo Cafe—I suppose, better to watch the passing downtown scene should anything come to pass! Members of the CBRT change from time to time, since the qualifications are minimal. Subjects are wide ranging, opinions are limitless, pithy and/or thoughty, and occasionally make sense. Well, enough for background!

Over the years, it has been customary to rotate the coffee buying among the regulars at the table. Then a few months ago several of the gamey members began to toss for the tab and three weeks ago, included Lefty the waitress in the toss. Well, Lefty has got to be the unluckiest morning waitress in the county, for she has picked up every tab since this custom began—at least until Monday, when she refused to play again. Everyone knew of course that she didn't have any spare change—if Lefty had any source of funds she wouldn't be working the Apollo! And no waitress at the Apollo will have a big income tax concern from non-reported tips!!

Everyone knew all of that, but still wanted Lefty to join in the game, so the discussion was on "how."

First bad idea was to charge more for the coffee when one of us lost and leave a big tip so Lefty could cover her losses. Hare-brain idea!

Another suggestion was to have Lefty charge the other customers a little bit more for their coffee to make up for what we were not paying.

Well right then and there, all that ISMS vicarious reading that I've been doing paid off! "Say," said I, "That sounds like what is called 'cost shifting'." Got everyone's attention right on the spot!! Unfortunately I couldn't hold the spotlight because I made the tactical error of trying to explain what I meant by that, which will teach me in the future to quit while I'm ahead.

The conversational ebb and flow ebbed away from me and flowed toward those looking more toward application and less to concept. More suggestions were made, until Lefty came through with real finality and laid it on the line. "You mid-morning turkeys, have only two choices," put in Lefty. "One, pay for your coffee when you get it; two, don't have coffee and don't pay for it. The third choice of keeping on drinking coffee at your same rate of consumption and having someone else pay, ain't no choice at all!"

Lefty won't make it as a grammarian, but she's right on target with cold country logic!!!

Getting back to my reading on 'cost shifting,' it would seem to me that the basic problem exists only as long as all you health care people keep on spending our money at the same rate—as though the money was still coming in—when it isn't coming in. The way to obviate that cost shift—or so it would seem to my uninformed but objective mind—would be not to spend it in the first place, or to spend absolutely only what is essential so that the amount of cost shifted would be minimal. Even Lefty probably wouldn't have raised the objection if she hadn't been such a consistent loser. Those upon whom the health care costs are being shifted might be able to afford a fair share of shift, but they are now moving into Lefty's category of constant losers—and who likes or will accept that state of affairs?

So, to borrow a page from Lefty's non-grammatical book, "The choice of keeping on with the same rate of consumption and having someone else pay, ain't no choice at all."

With best regards to you and the wonderful mismailers in the world, I remain,



Sincerely,
Emerson Goodwins

EKG

(Continued from page 87)

Answers: 1. B, C. 2. B, D.

This was a difficult patient management problem and a difficult cardiac arrhythmia. Sinus rhythm is present. The second, sixth, and tenth beats in the top strip are premature ventricular beats with a wide QRS complex and a compensatory pause. Each of these premature ventricular beats occur late in diastole with a prematurity index greater than one (RR′/QT interval). Yet the third premature ventricular beat initiates a run of probable ventricular tachycardia. It is a wide QRS tachycardia at a rate of 100 beats per minute on treatment with procainamide. It also responded somewhat to lidocaine and quinidine. As the seven beat run continues, its cycle length shortens, suggesting a Wenckebach exit block construction. It stopped spontaneously.

The narrow QRS following the ventricular tachycardia in the bottom strip as well as the beat following the first premature ventricular beat in the top strip have short PR intervals and are likely junctional escape beats. A recent study by Huang of cardiomyopathy patients using ambulatory ECG showed a high prevalence of complex ventricular arrhythmias.[1] Most bursts of ventricular tachycardia were initiated by later occurring premature ventricular beats. The significance of these ventricular arrhythmias in patients with severe congestive heart failure is not clear as yet. Myocardial biopsy has been helpful in some of these patients and very specific. However, sampling error is still a problem and a negative biopsy does not rule out the diagnosis of myocarditis. Gallium 67 uptake over the heart has been seen in myocarditis but also in infective endocarditis and myocardial abscess. It is a noninvasive indicator of inflammation. Immunosuppression has been useful in some selected patients but not in all of this group of patients with heart disease of diverse etiologies.[2] This patient's heart failure continued to worsen. A cardiac transplant was suggested but he refused. He died at home a month later. ◀

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1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Pfizer LABORATORIES DIVISION
PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

[*] Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Pulse of the ISMS Auxiliary

AMA-ERF

By Susanne Webb, ISMSA President

We did it again! I am proud and pleased to announce that, at the AMA Auxiliary Annual Meeting in Chicago on June 19-22, Illinois won the top two awards for total AMA-ERF contributions. Auxiliary members contributed a total of $149,367.92 and auxiliary members and physicians combined contributed a grand total of $177,013.20. Congratulations to Aggie Reddies and Evelyn Hodes who accepted the awards for Illinois. And a great big thank you to all of you who helped to make this possible.

What is AMA-ERF and how are these funds spent? AMA-ERF is the American Medical Association Education and Research Foundation. Its goals are to help further medical education, provide financial assistance to medical students and residents and further scientific and medical research.

Contributions may be designated to benefit the medical school of your choice and be further designated as unrestricted funds or as student loan funds. Unrestricted funds are used where most needed, such as building maintenance, faculty salaries or library books.

AMA-ERF has a newly established Medical Student Assistance Fund. Contributions are used to pay for educational expenses of students whose need is recognized by their schools. Students are informed that these funds are provided by the foundation.

Nationally, total contributions this year were $1,854,666.19. The AMA Auxiliary has announced a goal of $2 million for the coming year. Let us accept this challenge and continue our outstanding support of this foundation to ensure the future of quality medical care in this country.

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

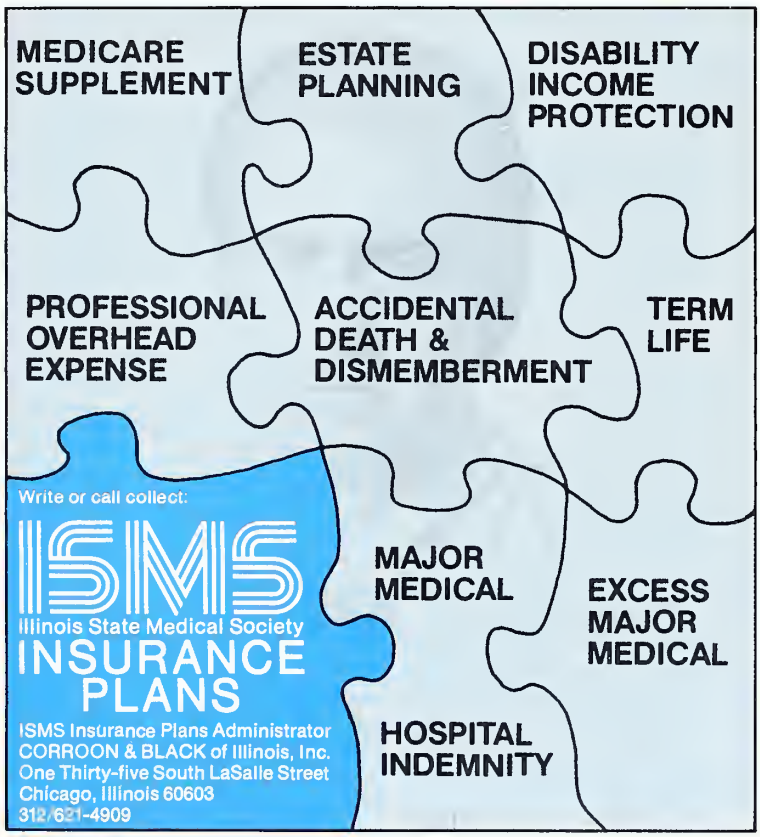
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A—(Acronymosis)

It probably started in the Garden of Eden. Eve: *"ADAM"* (Adam, darling, apple, munch). Adam: *"EVE"* (Eve, verily entrancing). The result was *XES*—(Exodus from Eden with the serpent).

In our innocence as babes in the art of love *(BAL)*, specifically puppy love *(PL)*, we would write notes to each other and tempted our fates if the envelopes were sealed with a kiss *(SWAK)*. *SWA* big *K (SWABK)* or SW love and K *(SWLAK)* or many other combinations were limited only by correspondents' imagination and ardor *(CIA)*.

It became extensively societally popular *(ESP)* during the depression years to use acronyms for governmental agencies which were to save us all from poverty and despair *(PAD)* during those dismally depressed times *(DDT) e.g., NRA, WPA, FERA....* One can cross the city of Washington or even the whole country from acronym to acronym without once touching soil *(TS) e.g., HEW,* oops *HHS, DE, DEA, CETA, COTA, ad infinitum (AI)*.

By now, acronyms have become a way of life *(WOL)*, not only in governmental gobblydgook *(GG)* and in all branches of science *(BS)*, but also in medical sciences *(MS)* and philosophical doctrines *(PHD)*. Some would say that *BS, MS* and *PhD* have another connotation. Everyone knows what *BS* stands for, *MS* is more of the same and *PhD* means that it is piled high and deep. In fact they cover the associated specialties of philosophy *(ASP)* as well as the associated specialties of science *(ASS)*.

Some acronyms are so well known that one no longer needs to define them (or does one?): *SOB*—shortness of breath; *BSA*—body surface area; *PG*—prostaglandins, with many subsets; *LP*—lymphocytic predominant Hodgkin's disease; *VIP*—vasoactive intestinal peptide; *TM*—temperomandibular; *CAMP*—cyclic adenosine monophosphate; *PS*—pathological stage and *CAN*—continually ad nauseam.

Some acronyms can be interpreted in several ways: *CPC*—chronic passive congestion, or clinico-pathologic conference; *LMP*—last menstrual period or large medical practice; *PET*—positron emission tomograph—or what you keep at home for pleasure and enjoyment; *AMA*—against medical advice or American Manufacturer's Association, or even American Medical Association; *CEA*—Carcinoembryonic antigen or cost effectiveness analysis and *CAN*—you know this by now.

Some acronyms tend to cause confusion by being almost but not quite associated by the same or similar letters: *DST*—dexamethasone suppression test would be misunderstood by many as daylight saving time, unrelated to *DSA*—digital subtraction angiography, which is not related even distantly to *DNA*—deoxynucleic acid which is related to *DRA*—deoxyribonucleic acid. None of the above have any connection with *DSR*—dynamic spatial reconstructor or *DAR*—Daughters of the American Revolution. *RMSF*—Rocky Mountain spotted fever has no distant romantic nostalgic relation to *RCMP*—Royal Canadian Mounted Police. *MED*—Minimal erythema dose has nothing to do with *MD*—A school for budding M.D.'s or muscular dystrophy; also a member of an esteemed profession. *VZIG*—Varicella Zoster Immune Globulin has no relation to U.S. foreign policy makers even if it is a foreign protein. *CBA*—cost benefit analysis is related to *CEA*—cost effective analysis, both of which concern a *CPA*—certified public accountant—to indicate occasional relationship between similar acronyms. *CAN*—our old friend.

Some acronyms are downright overwhelming or threatening *(DOT)*. They may cause us a delirium of association *(DOA)* which while not fatal, can be distressing: *GMENAC*—Graduate Medical Education Advisory Council; *NIADDKD*—National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases; *PIQUA*—Private Initiative in Quality Assurance; *CAN*—as before or *CAD*—continued *ad destructionem!*

We must be careful how we use acronyms. Who wants to be a *CAD*, even if he may have it (Coronary Artery Disease). Don't *TSH* an angry wife or husband even if it (thyroid stimulating hormone) is working overtime. Don't punch any *TS* tickets, no matter how deserving, for Tourettes Syndrome. *PHPT* is maybe what an irate feline might do when afflicted with it (primary hyperthyroidism). An ardent SS Nazi wouldn't want to be found dead with *SS* (sickle cell anemia).

LAG (lymphangiogram) has nothing to do with the lid lag sign of hyperthyroidism. The officials who are trying to solve the *RTA* crises in many cities might settle for renal tubular acidosis, which might be more amenable to solution.

How fascinating it would be to collect all acronyms and start a club of favorite ones, or a thesaurus of acronyms. I can visualize acronym bees instead of spelling bees, with the victor's initials added to the list of acronyms, to be honored by posterity. Where might it all end: wisps of whimsey *(WOW)* or wonder of wonders *(WOW)?*

I don't know.

Sign me *PCR*. ◀

(*PCR* is *AKA* Peter C. Rumore, *M.D., F.A.C.S.* Effingham)

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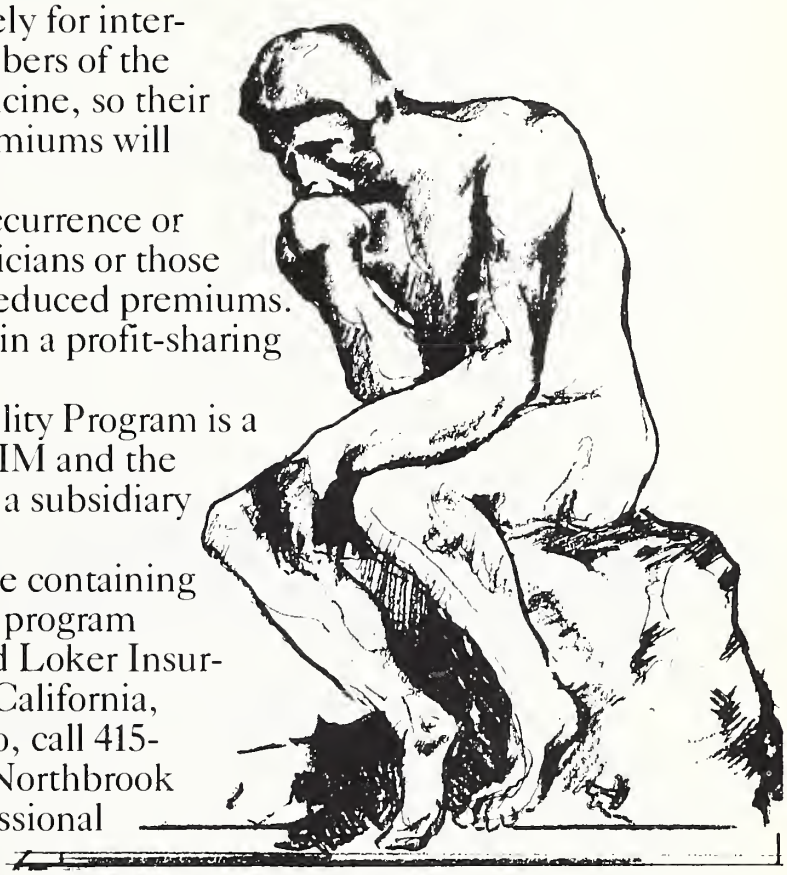
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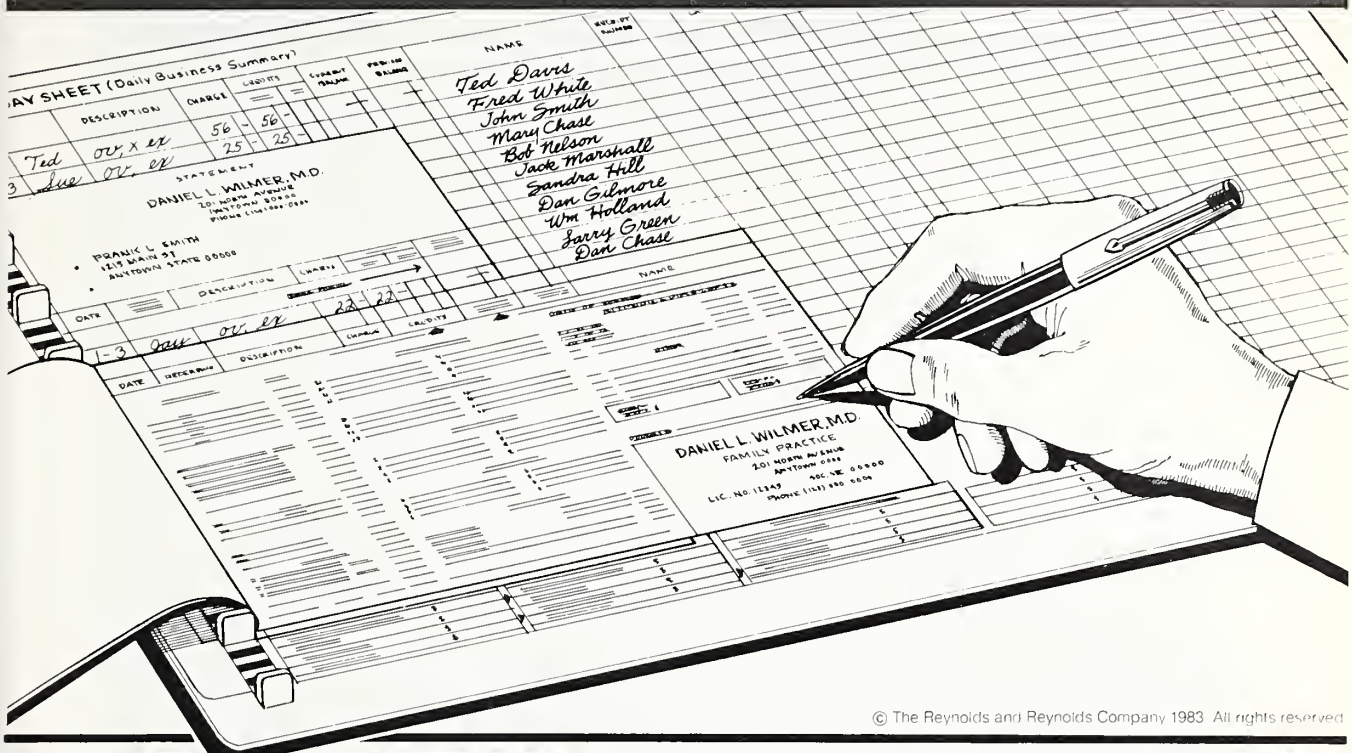


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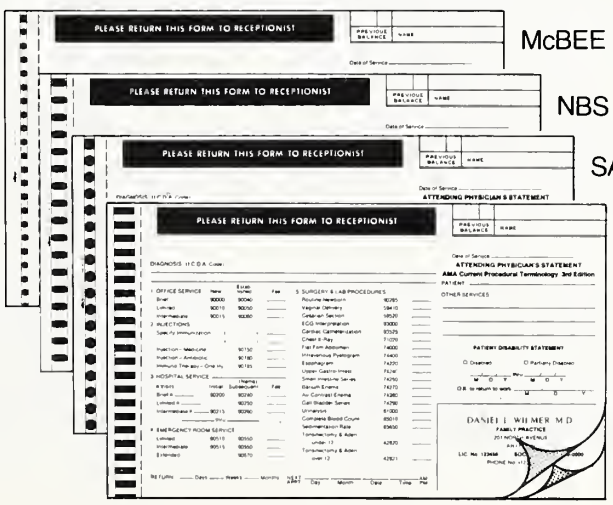
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The Incidence of Down Syndrome In Three Counties in Southern Illinois During the Years 1974-1978

By Gregory L. Smith, M.D., Paul Feldman And George F. Smith, M.D./Chicago

A survey of the incidence of Down syndrome in Jackson, Perry and Williamson counties in southern Illinois, over a five year period (1974-78), identifed 23 Down syndrome children. Most (15) of the children were from Jackson county. A large proportion of the children were born in the year 1978. An unusually large number of the children were born to mothers in their late teens and early twenties. There were five times the expected number of Down syndrome children in the five year period in Jackson county. Perry and Williamson counties had three and 1.4 times the expected number of Down syndrome children respectively. The increased incidence could not be explained by an aging maternal population in these areas. No infectious, toxic or radioactive source was found to be associated with this cluster of Down syndrome children.

There are hundreds of clinical conditions with which mental retardation is associated, but of all these conditions Down syndrome is one of the most common known to man.[1] It certainly is our most frequently occurring chromosomal defect, producing both physical and mental abnormalities. Down syndrome occurs once in 660 live births.[2] Each year in this country approximately 5000 Down syndrome infants are born. Twice this number are conceived but result in early spontaneous abortions. On a world-wide basis, approximately 60,000 Down syndrome infants are born annually and approximately twice this number are spontaneously aborted.

Down syndrome occurs when there is triplication on the number 21 chromosome in the newly formed zygote. Down syndrome may be due to a translocation of chromosome 21 to another chromosome or by nondisjunction of the 21 chromosome which occurs in an ovum or a sperm. While Down syndrome is identified with an extra number 21 chromosome, in reality it is now known that only the lower two thirds of the chromosome is needed to produce the syndrome.[1]

Down syndrome is important biologically because the process of nondisjunction which produces the extra chromosome is a reflection of an abnormal biological or clinical process occurring at a high rate in human beings. Nondisjunction is highly correlated with maternal and paternal aging and, while Down syndrome is the most common disease produced by chromosomal nondisjunction,[1,3,4] many other chromosomal abnormalities are caused by this same process and are associated with human aging. The amount of human pathology produced by Down syndrome is great, but the magnitude of the pathology is tremendous when all the other clinical conditions produced by chromosomal abnormalities are added to it. The common factor in the production of all this human pathology is the association of nondisjunction and human aging.

It is evident that any clues as to the cause or causes of nondisjunction in Down syndrome will also be of major importance to the understanding of the production of a large amount of human pathology caused by other chromosomally abnormal conditions as well.

Over the years, an empirical observation was made that in a particular area of southern Illinois the number of babies born with Down syndrome was unusually high in proportion to the total local

Table 1
Expected* and Observed Number of Down Syndrome Cases by Year and County.

	Jackson County N = 15					Perry County N = 4					Williamson County N = 4				
	1974	1975	1976	1977	1978	1974	1975	1976	1977	1978	1974	1975	1976	1977	1978
Expected	0.59	0.61	0.61	0.60	0.61	0.25	0.29	0.24	0.30	0.25	0.54	0.60	0.54	0.57	0.62
Observed	2	3	2	3	5	2	0	0	1	1	0	1	0	1	2
Ratio o/e**	3.38	4.92	3.28	5.00	8.19	8.00	0	0	3.33	4.00	0	1.66	0	1.75	3.22

**expected incidence figures*
***observed divided by expected incidence*

population.[5] Epidemiologically, Down syndrome has been difficult to study because the condition occurs in all populations at about the same relative frequency. Therefore, we postulated that any deviation from this standard frequency could offer a clue to the process of nondisjunction in man.[1]

The area under suspicion for the increased incidence of Down syndrome included contiguous parts of southern Illinois, Kentucky and Tennessee. It was decided to sample this area by studying the three adjacent southern Illinois counties of Perry, Williamson and Jackson. These counties were chosen since statistical records were available from the public health departments, and also the Down syndrome parents' group in the area was united, well organized and cooperative. In addition, the facilities of Southern Illinois University, located in Jackson county, were placed at our disposal. All of these factors combined assured us of a high degree of accuracy in the incidence figures recoverable in this area.

Method

The five year period from 1974 to 1978 was selected for the study since the public health department had available and complete vital statistics for these years. The Illinois Public Health Department in Springfield provided the number of live births for the three counties being surveyed.

The six hospitals in the three counties being surveyed provided the number of Down syndrome births and maternal ages for each year of the survey. It was also learned that certain high risk pregnancies were referred to a perinatologist in St. Louis for amniocentesis. Down syndrome births and maternal ages were collected from St. Louis. There were no abortions of Down syndrome fetuses recorded for the years of the survey.

In an effort to include all Down syndrome children born during the years of the survey, numerous sources were used to verify figures. For example, local schools for the handicapped were contacted, and the local Down syndrome parents' group supplied us with names, birthdates, and maternal ages of all the Down syndrome children in the tri-county area. In addition to this, in order not to miss recording any Down syndrome children, an interview session for Down syndrome parents and their children was announced by the local radio and television stations and newspapers. The names, birthdates and maternal ages of Down syndrome children were collected at this meeting. The material collected was carefully checked to make certain that no Down syndrome child was counted twice. Each case was reviewed to make certain that the Down syndrome child belonged in the sample population for the counties and years included in the survey.

Results and Conclusions

During the five year period of survey, there were 3,548 births in Jackson Country and 1,607 and 3,461 in Perry and Williamson Counties respectively. An analysis of variance was done to determine if there was any difference in the birth rates within and among counties during the years of the survey. The analysis showed that there was no significant variation for the birth rates from year to year within a county, nor was there a significant variation among the three counties. In addition, there was no significant difference in mean maternal ages for all live births for the three counties.

The collected data did show that there was a total of 23 Down syndrome infants born, 14 males and 9 females, in the three counties during the years of the survey. Significantly more Down syndrome infants were born during the survey year 1978 than during the other four years. The majority of infants born in 1978 were born to mothers living in Jackson county. It was found that Jackson county had from three to eight times more Down syndrome infants born than would be expected

Table 2
Expected* and Observed Number of Down Syndrome Cases for Period 1974-1978 by Country

County	Expected	Observed	O/E
Jackson	3.02	15	4.97 (p 0.005)
Perry	1.33	4	3.00 (p 0.01)
Williamson	2.83	4	1.41 (p 0.05)

Table 3
Mean Maternal Age of Live Births and Down Syndrome Cases by County.

	Mean Maternal Age Live Births	Mean Maternal Age D.S.* Cases
Jackson	25.1 (N = 3458)	26.9 (N = 15)
Perry	24.6 (N = 1607)	29.0 (N = 4)
Williamson	24.6 (N = 3461)	24.3 (N = 4)

Down syndrome

during the five years surveyed. During the year 1978 in Jackson county, there were 1.5 to 2.5 more babies born with Down syndrome than in any of the other four years studied (see Table 1).

The incidence of Down syndrome varied from year to year for both Perry and Williamson counties. For these counties, during some of the years, the number of Down syndrome infants was less than expected and for other years the number was more than expected (see Table 1). However, all three counties had a greater number than expected of Down syndrome infants born during the five year period covered by the survey (see Table 2). The expected incidence of Down syndrome newborn infants based upon maternal age is taken from the work of Collman and Stoller (1962) in a survey of a large Australian population.

During the five years studied, Jackson county had nearly five times more Down syndrome infants born than would have been expected and Williamson and Perry counties had 1.4 and 3.0 times as many respectively (see Table 2).

There was no significant difference between the mean maternal ages for all normal live births for the three counties. However, the mean maternal age for mothers giving birth to Down syndrome infants was slightly higher in Jackson and Perry counties than the mean maternal ages for normal births in these counties (see Table 3). In Williamson county the mean maternal ages for the two groups did not differ significantly (see Table 3). There was considerable variation of the mean maternal ages for the Down syndrome newborns in the three counties. It is of interest that the average maternal age for the Down syndrome newborns in Jackson county in 1978 was 21.6 years.

Based upon the number of normal infants born and the maternal ages during the five years studied, data suggest that the populations were rather stable and that the relative numbers of normal infants born in each county during the five year period remained constant. There was, however, an increased incidence of Down syndrome infants born in the tri-county area for the five year period under observation. The greatest number of these infants were born in Jackson County where the increase was nearly five times the number that would have been expected. During 1978, Jackson County had twice as many cases of Down syndrome as in any of the other years surveyed. It was also observed that these infants were born to relatively young mothers.

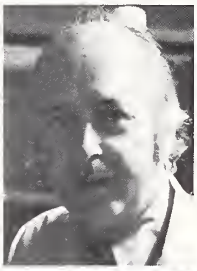
The interpretation of this type of data in Down syndrome always presents difficulties, since the numbers are relatively small and the incidence is so highly correlated with the maternal ages of the population being studied. Undoubtedly, the paternal ages also have to be considered since we now know that approximately one fourth of all the cases are due to paternal nondisjunction. Taking into consideration the limitations imposed in interpreting these data, there has been a relative increase in the incidence of Down syndrome in these three areas during the years of the survey and the greatest increase occurred in Jackson county during the year 1978. Based upon our present knowledge, these increases can not be explained by an aging maternal population in these areas.

A search for unusual environmental factors occurring in the tri-county area during the years of the survey was attempted in an attempt explain the increased risk figures for Down syndrome. An extensive review of the tri-county area public health department statistics showed that there was no association with infectious diseases,[6] toxins or radioactive sources that could account for the cluster of newborn Down syndrome infants. ◀

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Illinois' Perinatal Records
Prospects for Regional Information Systems

By Karen S. Tarpey, Dr. P. H., Donald R. Dye, M.D.,
Edward A. Lichter, M.D. and M. Stewart West/Chicago

Good record systems lead to better medical care and to more effective planning for resource allocations. The State of Illinois regional perinatal network participated in a study to assess the nature and quality of its records and reporting practices. A questionnaire was sent to 216 maternity hospitals and perinatal centers participating in the regional perinatal network. Eighty-eight percent of the institutions reported on the types of records used, the nature of the patient information collected and the level of satisfaction with current record systems. The survey data affirmed the consensus that the record must identify the high risk patient and be designed to improve reliability of information with minimal duplication, incompleteness and fragmentation. It is now feasible to construct an acceptable, workable record system in a complex care system like the State of Illinois that addresses the consensus goals and the major concerns expressed by the users.

In 1974, a statewide plan was developed for regionalization of graded levels of perinatal care—the Illinois Perinatal Plan.[1] One of the initial objectives of the plan was to establish a uniform data reporting system for perinatal outcomes, including morbidity and mortality for the entire state. Each region was given the latitude to implement objectives according to local interests and discretion. Consequently, regional perinatal centers and their referring hospitals were slow to institute a systematic uniform record and reporting system. Some perinatal centers had developed a uniform record system within their own institutions, but no regional or statewide data system had been put into effect.

Lack of uniform recording and reporting practices is a recognized obstacle in developing a data system capable of supporting the regional perinatal concept and the care of high risk patients. At the 1980 Surgeon General's Workshop on Maternal and Infant Health, specialists strongly recommended that data systems be developed to improve the management of perinatal programs and that these systems include risk evaluation, a uniform patient data base, and the linkage of health and vital records.[2] These recommendations are based upon two premises: (1) risk evaluation and uniform patient assessment improves perinatal care and (2) a perinatal data base promotes efficient use of human and financial resources by targeting specific health problems.

Although state and local health department and perinatal program directors acknowledged the

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Karen S. Tarpey, Dr. P. H., is an associate professor of public health and research analyst at the division of women's health, Chicago Department of Health. An associate professor affiliated with the UI College of Nursing department of public health nursing, she has served as a public health nurse, and cites particular interest in maternal-child and school health.

Table 1
Number and Percent of Current Record Types and Reported Level of Satisfaction

Record Type	Satisfied and Somewhat Satisfied		Dissatisfied and Somewhat Dissatisfied		Total	
	N	%	N	%	N	%
Commercial	21	43.2	16	56.8	37	21.1
Staff Developed	48	50.0	48	50.0	96	54.9
Both Commercial and Staff Developed	9	37.5	15	62.5	24	13.7
Other Combinations	5	27.8	13	72.2	18	10.3
TOTAL	83	47.4	92	52.6	175[a]	100.0

[a] *Total repondents reporting level of satisfaction*

need to establish a uniform reporting system, they were concerned about the prospects of developing a uniform record and information system that would meet the needs of perinatal practitioners throughout the state. Because little information existed about perceived needs for recording and reporting, this survey was conducted to determine needs, practices and preferences among professionals directly involved in perinatal care. The goal of the survey was to help identify an information system that would satisfy the majority of practitioners and also to identify a target group for instituting a model uniform record system. The specific concerns addressed in the survey were: (1) to determine the base of support for a uniform perinatal record and information system; (2) to identify current types of perinatal records and differences in perceived levels of satisfaction; (3) to identify important characteristics of the perinatal record among professional groups, institutions and regions and (4) to determine the relationship among important characteristics and the extent to which these characteristics related to current practices and satisfaction reported by practitioners.

Materials and Methods

A questionnaire was mailed to 196 licensed maternity hospitals and to 20 perinatal centers participating in the Illinois perinatal network, 1979. The questionnaire sought information about the type of record used, the nature of the information recorded, and the purposes which the record served. In addition, the opinion of each respondent was sought about satisfaction with current records and desirable characteristics of a perinatal record. Pertinent demographic questions were included. One hundred eighty-four (88.5%) responses were received from the 208 institutions providing maternity services at the time of the survey. They are the basis for this report.

Results

Respondents represented maternity hospitals and perinatal centers uniformly among the five regions of the state. Most were professional practitioners directly involved in perinatal care. Sixty-three percent of the respondents were professional nurses and 22% were physicians. Most nurse respondents identified their job category as supervisory. Among physician respondents, 15 were perinatal center directors or chiefs; a group whose viewpoint is respected and may determine regional perinatal practice. Other survey respondents included medical record staff and hospital administrators, 10% and 5% respectively. Although respondents represented four different professional categories, the analyses indicated similar responses regardless of category.

Inventory of the types of perinatal records in use revealed a loose structure of commonality among the records as well as many highly individualized forms. Respondents described four types of records. As shown in Table 1, 21% reported using commercially purchased records; 23% reported using various combinations of records and more than half (56%) of the respondents reported using a staff developed record. But this finding suggests that a great amount of time, energy and expense has been invested among 102 institutions developing and implementing records

Table 2
Number of Respondents Circling a Listed Concern, Singly and in Combination Among Respondents Circling At Least One Concern[a]

Concerns	Total	Number of Respondents			
		Single Concern	One of 2 Concerns	One of 3 Concerns	One of 4 Concerns
Incomplete	60	19	26	8	7
Duplicative	57	12	15	18	12
Fragmented	43	4	22	8	9
Too Time Consuming	43	7	11	16	9
Too Long	20	2	7	7	4
Too Difficult to Read	12	0	5	3	4
Write in Concerns	24	7	6	4	7
Total Number of Respondents Circling at Least One Concern		51	46	21	12

[a] *130 respondents circled at least one concern*

which, although common to one area of practice, are unique to each institution's staff preferences, practices and patients. Admittedly, any recording system must be flexible and adaptable to the needs of the patients and practitioners in the local community. However, when the type of record was compared with the perceived level of satisfaction, essentially no association was found between perceived satisfaction and record type, regardless of regional differences. Among perinatal center respondents, 76% reported dissatisfaction with current records, and as previously noted, these respondents were primarily physicians.

Choosing from a list of 12 plausible record problem statements, over 71% of the respondents identified at least one specific concern related to staff's dissatisfaction with current records. Table 2 presents the concerns most frequently reported. "Incomplete" was most frequently identified in both single and multiple responses, followed by "duplicative" and "fragmented." These three major concerns were common among all categories of respondents and were also cited in the write-in responses. Perinatal center respondents reported the greatest number of concerns. Over half (57%) indicated that as many as three to six of the listed concerns had been expressed by their staff, which may also be related to the frequency of dissatisfaction perceived.

Table 3 shows the level of importance assigned by respondents to characteristics of a perinatal record. Overall, the highest frequency of "very important" responses appeared as follows: screen high risk pregnancies (92%); increase reliability of information (90%); provide uniform assessment (82%); improve communication between the physician and the hospital (79%); be easy to complete (76%) and preserve the rationale for treatment (74%). When the "very important" and the "somewhat important" characteristics were compared, responses proved essentially uniform across institutional types, geographic regions and professional job classifications. Because of the consistency among responses and respondents on this question and on a ranking question about the same characteristics, it became plausible to generate a set of criteria to evaluate current perinatal records. The seven "most important" characteristics became the criteria for evaluating each respondent's current perinatal record and also formed the basis for the perinatal record evaluation form shown in Figure 1.

Each institution's current record was scored according to whether it met the criteria in responses on the questionnaire. The average score was 4.1 points (out of a possible total of 7). Of the 77 institutions scoring above the mean, 52% reported satisfaction and 48% dissatisfaction with current records; of the 98 institutions scoring be-

Table 3
Number and Percent of 184 Respondents Indicating Levels of Importance To Listed Characteristics of a Perinatal Record

Characteristics	Level of Importance: Very Important N	%	Somewhat Important N	%	Not Important N	%	No Opinion N	%	No Response N	%
Provides uniform assessment	150	81.6	29	15.7			3	1.6	2	1.1
Screens high risk pregnancies	170	92.4	12	6.6			1	0.5	1	0.5
Is easy to complete	139	75.6	41	22.3	3	1.6			1	0.5
Saves time	122	66.4	55	29.8	4	2.2	2	1.1	1	0.5
Is inexpensive	60	32.8	103	55.8	16	8.7	3	1.6	2	1.1
Is easily audited	95	51.6	77	41.9	4	2.2	5	2.7	3	1.6
Increases reliability of information	165	90.0	16	8.5	1	0.5	1	0.5	1	0.5
Preserves the rationale for treatment	137	74.5	37	20.1	1	0.5	7	3.8	2	1.1
Facilitates data collection	88	47.8	85	46.3	5	2.8	3	1.6	3	1.6
Can be used as a teaching tool	82	44.5	76	41.3	16	8.6	7	4.0	3	1.6
Can be used by various disciplines	75	40.7	83	45.1	18	9.9	5	2.7	3	1.6
Improves communication between physician and hospital	144	78.3	33	17.9	2	1.1	3	1.6	2	1.1

low the mean, 49% had reported satisfaction and 51% dissatisfaction. Further comparison of record performance scores with "very important" characteristics, and perceived satisfaction helped to identify a possible base of support for improving perinatal records. Although this analysis was limited to a subset of data, it showed that only 20 maternity hospitals and one perinatal center reported using a record which met high performance criteria and was also perceived as satisfactory to staff. It also showed that more than 50% of the respondents who agreed with the "very important" record characteristics reported dissatisfaction with current records regardless of the finding that these records achieved average to good overall performance scores. And within this subset, 87% of the perinatal center respondents had reported dissatisfaction. Inspection of the distribution of performance scores among these perinatal centers showed that as many as six centers should improve the qualitative aspects of their current records, (Figure 1, items 1-3) and as many as three centers should improve the quantitative aspects of their current records (Figure 1, items 4-6).

Discussion

We learned that perinatal practitioners identified similar problems and shared a consensus about the purposes and important characteristics of perinatal records. Responses indicated that a wide variety of record types are used among perinatal centers and maternity hospitals throughout the regions. This finding was similar to that of Jennet, *et al.*[4], who inventoried perinatal records prior to developing a uniform regional record for the Arizona perinatal network. While our data showed that over 50% of the institutions use a staff-developed record, essentially no relationship existed between the type of record used and the level of satisfaction with records perceived among staff. This leads us to suggest that, regardless of regional differences, a uniform record and information system designed to meet the needs identified by practitioners should be at least as satisfactory as the various records currently in

Figure 1
PERINATAL RECORD EVALUATION FORM

In order to estimate how useful your current perinatal records are answer the following questions.

	YES	NO
1. Does your current perinatal record contain a standardized format for the thorough assessment of each patient?	☐	☐
2. Does your current perinatal record enable you to identify high risk pregnancies, high risk maternal and infant patients?	☐	☐
3. Are your current perinatal records problem oriented, that is, does the record provide for designation by order of importance, the major health related problems encountered during the perinatal period?	☐	☐
4. Is the information in your perinatal records tabulated for the statistical purposes of generating monthly/annual reports?	☐	☐
5. Is the information in your perinatal records tabulated for purposes of comparison over time?	☐	☐
6. Is the information from your perinatal records tabulated for research purposes?	☐	☐
7. Are your current perinatal records regularly audited?	☐	☐

OVERALL RECORD PERFORMANCE SCORE:

	YES	NO
1.	1	0
2.	1	0
3.	1	0
4.	1	0
5.	1	0
6.	1	0
7.	1	0

For each of the above questions the most desirable response earns one point. A score of 7 is the highest possible overall performance score. A score ranging from 5-6 is above average suggesting a very effective record. A score ranging from 3-4 is average suggesting a somewhat useful record, while a score of 2 or below implies that the record is serving little purpose and should be improved.

use. Braunstein[5] reported that differences in medical records and codes has been noted as a serious concern among practitioners and researchers in different medical practices. Standardization of records in the multi-physician, multi-practitioner perinatal network should be a positive step in this area.

Because perinatal centers act as receiving hospitals for high risk mothers and infants, it would not seem unusual that they reported dissatisfaction with current records more frequently than other maternity hospitals. The finding that perinatal centers identified "incomplete" and "duplicative" as their primary concern was also understandable. "Completeness" of record information is essential in determining medical and nursing judgments about large, diverse and often critically ill patient populations. For the same reason, the record must be concise, and "duplicativeness" in patient records more often obscures than illuminates the process of perinatal care. It also complicates the process of reducing vital information to an accurate, compact source of data which can be easily stored and retrieved. In addition, perinatal centers must rely on concise documentation in order to be reimbursed for the care of the high risk patient. But "fragmentation," another frequently expressed concern, admits to the breakdown of thought, behavior and communication existing in current perinatal record systems.

If maternity hospitals serve primarily the normal, low-risk patient populations, this fact did not diminish staff concerns reported about their records. Of the 24 respondents who wrote-in specific concerns related to satisfaction, 87.5% were received from maternity hospitals throughout the regions. These respondents commented that records were frequently incomplete, and record information frequently inconsistent. Some respondents requested information about uniform records and standardized high risk criteria.

In addition to identifying common concerns about perinatal records, respondents indicated a consensus about desirable characteristics of a model record. Among 12 record characteristics listed on the questionnaire, the characteristic ranked as "most important" was for the record to "identify high risk patients." Several reasons may explain this consensus. A record that indicates the risk status of a patient can alert practitioners to the level of care optimally required. It may signal the need for a referral, consultation or possibly a transfer to the most appropriate facility for care. The development of high risk screening and scoring techniques over the past decade has increased our knowledge and ability to improve perinatal services. Practitioners are now able to calculate the probability of risk for individual pregnancy outcomes, and also determine the continuum of risk factors which affect specific populations.[6,7] Furthermore, risk screening techniques facilitate the assessment of important perinatal variables as they exist and as they change with improvements in health care and over time.[8] They provide optimal criteria to determine acceptable standard levels of care according to varying degrees of risk.

General Comments

For public health department maternity clinics, which in 1976 provided prenatal care for 12.8% of the live deliveries in this country,[9] risk scoring has its greatest potential as a screening and periodic assessment process rather than a means of dictating the final management of pregnancy. In 1977, approximately one-third of the 14,000 prenatal patients attending Chicago Health Department maternity clinics were designated as high risk pregnancies due to medical, obstetrical and socio-economic conditions. A high risk screening and scoring system was introduced in order to direct attention to these patients and facilitate transfer of complete assessment data from the clinics to the hospital of delivery. For these patients, a high score validated the need for referral or transport to the most appropriate hospital. For the receiving hospital, it provided a basic accounting index of patient services and reimbursement requirements. Admittedly, if the concept of high risk is not considered important by practitioners, or is not chosen to be recognized, a risk score on a perinatal record would have little value. However, it does draw attention to the patient.

In addition to identifying the high risk patient, practitioners reported that they value a record which "provides a uniform assessment" of patients, "preserves the rationale for treatment" and is also "easy to complete." These record characteristics have been incorporated into the recording systems of several perinatal programs.[4,7,8] Checklist formats provide the greatest uniformity, preserve the logic of care, and require the least amount of effort to complete. A checklist of patient information can also be computerized far more easily than the diversely constructed narratives which are presently maintained as patient records. When uniform record checklists are merged into computer files, it becomes possible to generate pertinent summaries of patient information in a timely and accurate manner which benefits the hospital, the physician and ultimately, the patient.[10] Computerized checklist records can also improve reliability of information, (another "very important" characteristic identified among the respondents).

While 98.6% of the respondents indicated that records should be designed to improve reliability, only 4% reported that record reliability was perceived as a concern among staff. Because the term, "reliability" was not defined on the questionnaire, respondents may have interpreted reliability as validity, and by omitting it as a concern, implied that the information in their current perinatal records truly reflected patient needs and services. On the other hand, the fact that so few respondents failed to list it as a concern may imply that too few practitioners are aware, or are willing to admit, that the problem of record reliability affects their own practice as well as health and vital statistics.

Evaluations of medical record data provide evidence that information is too often unreliable, incomplete and at times conflicting. Furthermore, these deficiencies have been shown to bias mortality and morbidity figures in general, and particularly for some ethnic and disadvantaged high risk sub-populations.[11,12] A human factor predominates in solving the problems of record deficiencies. However, until we admit that unreliable data disrupt not only private practice but the broader practice of perinatal medicine, we can expect little effort will be made to correct these deficiencies voluntarily.

According to the responses from this survey, too few practitioners place a high value on collected data. Only 48% of the respondents reported that "improving data collection" was a very important characteristic of perinatal records. Yet, the information from both medical and vital records must be combined if we aim to assess pregnancy outcomes more accurately, monitor

hospital performance, evaluate regional programs, and ultimately improve standards of perinatal care.

Using the "very important" characteristics as criteria, a record performance score for each respondent's current record was generated. Overall, the record performance score was not associated with a particular type of record, nor the professional category of the respondent. Proportionately more perinatal centers and Northeast regional maternity hospitals achieved high record performance scores. Only slightly more satisfaction than dissatisfaction was reported among those respondents for whom the overall performance score was above average. By comparing the record performance score with individual responses about very important characteristics and perceived satisfaction, a group of respondents was identified which may support a constructive change in recording practices. Perinatal centers appeared to be the logical group to support uniform perinatal record practice. Their responses indicated more dissatisfaction, more staff concerns, and a stronger consensus on high performance criteria. Perinatal centers should support a uniform information system, not only because they serve a greater number of patients but also because they must also interface record information with a greater number of practitioners and with other maternity hospitals. Most perinatal centers have the facilities to support the technology of a computerized information system, and attract the necessary qualified staff.

Summary

This study is subject to the limitations of survey design. The responses represented the perceptions of the respondents, and we cannot measure their accuracy. Although factual data may be considered higher on the scale of evidence, there is no way of knowing whether the factual responses were any less speculative than the opinion responses. However, the survey achieved a high response rate from perinatal practitioners who hold positions requiring knowledge and professional experience in the subject. Subjected to analytical tests, their responses proved to be highly consistent. The consensus among respondents provided some insight and direction about criteria to include and concerns to address in a perinatal record system. On the basis of this information, the self-administering record evaluation test (Figure 1) was developed and sent to all surveyed institutions along with a report of the findings. Sixty-five (approximately one-third) of the original surveyed institutions responded to a follow-up inquiry about the results. Among these respondents 45 reported that the record evaluation test was helpful to staff, 39 recommended adoption of a uniform perinatal record and reporting system for their own institution, and 34 recommended its adoption at the regional level.

Perinatal information networks must continue to expand, but the impetus for developing such networks must come from health care providers themselves.[13] Hopefully, this report has not only heightened awareness about the importance of uniform perinatal records, but has also revived interest in further defining a regional information system, as specified in the Illinois Perinatal Plan. ◀

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Illinois Society, American Association of Medical Assistants

Medical Assisting: Then And Now

By Robin Bluestein, CMA-C

The field of medical assisting has undergone great changes in the last few decades. Medical assisting has received more recognition within the medical field due to several factors. First, there has been a great increase in practicing physicians and resultant need for more medical assistants. Second, there has been the advent of numerous programs for medical assisting (diploma as well as associate degree) throughout the country. Third, medical assisting has benefitted from the establishment of the American Association of Medical Assistants almost 27 years ago. My concern is with the changes that have occurred within the physician's office as the profession of medical assisting gained recognition and the medical assistant's responsibilities increased.

The term "medical assistant" was not always used to describe an individual who works under direction of a physician. Many offices employed nurses and lab technicians to perform clinical responsibilities. Their training and education was achieved either through a hospital program or through a four year college degree. In addition, a secretary or receptionist was responsible for any administrative duties. This person might have been trained in a trade school or on the job. Those individuals to whom the title "medical assistant" would apply performed primarily the administrative duties in the office and might have performed some basic clinical procedures (chemical urine checks, blood centrifuge, assisting in gynecological examinations). This might have occurred in a small practice employing one or two individuals where any laboratory work was sent out. The medical assistant's responsibilities were limited due to his/her education, training and the other health professionals working in the office.

Medical assisting has and is growing tremendously. The medical assistant's responsibilities are ever increasing. The Occupational Outlook Handbook (U.S. Department of Labor, Bureau of Labor Statistics, 1982-83 Ed.) describes the nature of the work of a medical assistant. A short excerpt states, "Clinical duties most commonly include: recording patient's height, weight, temperature and blood pressure; obtaining medical histories; performing simple laboratory tests; preparing patients for examination or treatment; cleaning and sterilizing instruments. They may answer the telephone, record and file patient data and medical records, fill out medical and insurance forms, schedule appointments, transcribe dictation and handle the bookkeeping and billing."

On the job training has become obsolete as the medical assistant's duties have grown. Schools and programs have been established specifically for medical assisting which teach the essential skills. Junior colleges offer a two-year associate degree which includes both general college courses, science courses and practical laboratory courses. Medical assistants have been replacing nurses/lab technicians and secretaries/receptionists in the physician's office. Responsibilities have increased with advanced training in schools (*eg.* venipuncture, electrocardiography, Xray taking and developing, and injections). In addition, with the additional responsibilities given to medical assistants, states may very well require some type of registration in the future, so the physician can be certain of the medical assistant's competency. Certification is presently offered by the American Association of Medical Assistants.

The profession of medical assisting has witnessed a greater responsibility for its members, excellent employment opportunities through the 1980's and greater recognition by other health professionals now and in the future.

Information regarding Illinois Society, AAMA may be obtained from Betty Kronemeyer, CMA, President, Illinois Society, 809 North 10th Street, Mascoutah, IL., 62258, or Lesa B. Greene, CMA-C, Chairman, Public Relations Committee, 8836 West Grand Avenue, River Grove, IL., 60171. ◂


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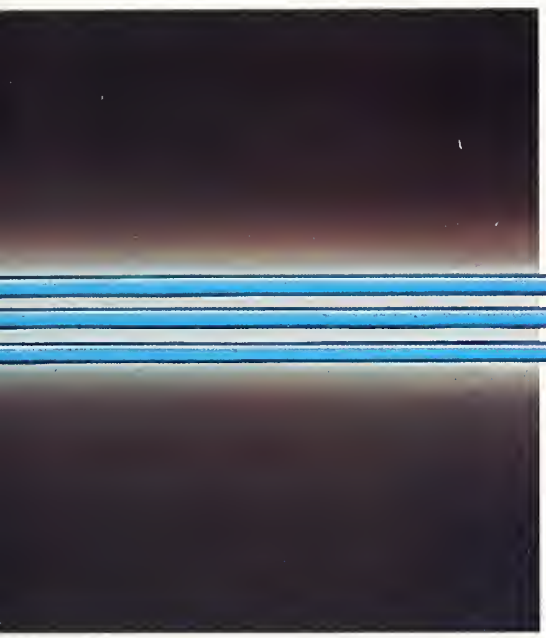
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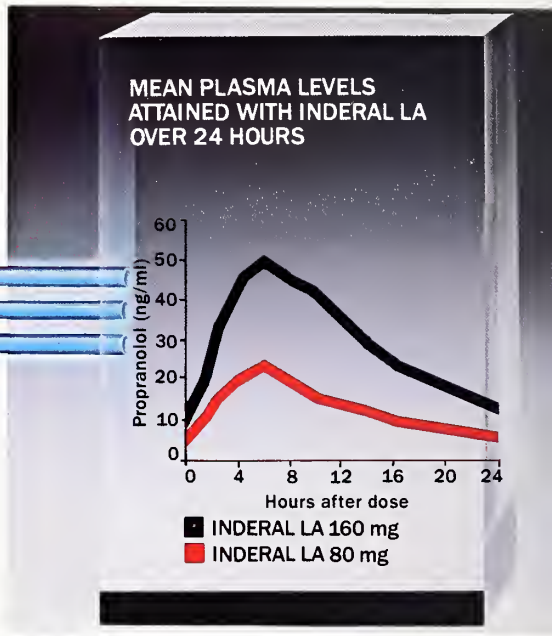
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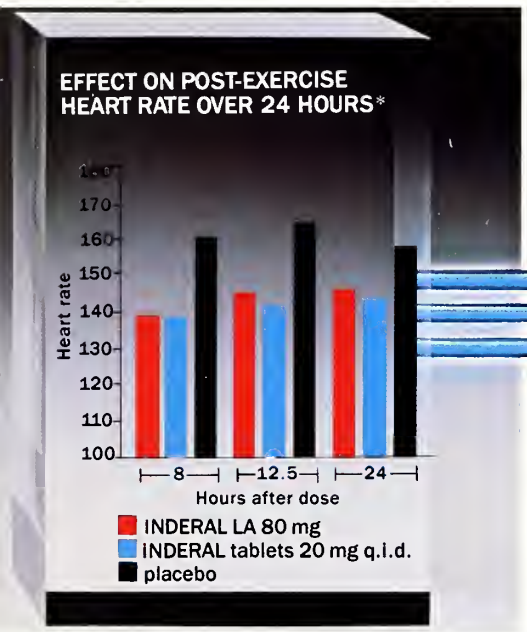
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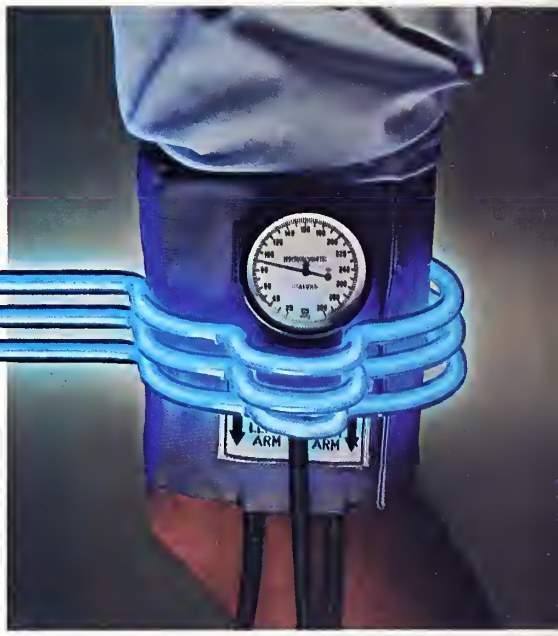
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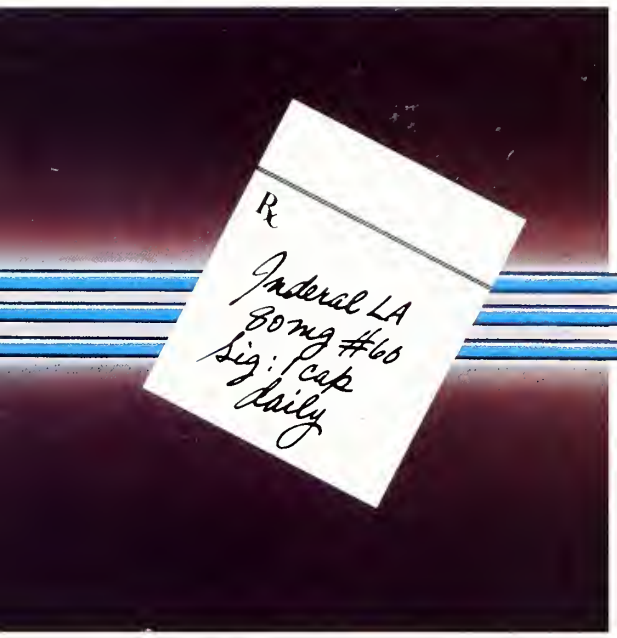
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INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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COMPUTERIZED TOMOGRAPHY

Primary Study For Low Back Pain

By Jack L. Melamed, M.D., F.A.C.R., Meline Pickus, M.D.
and Virgil Williams, M.D./Chicago

High resolution computerized tomography now makes it possible to visualize abnormalities of the lumbar spine without hospitalization or invasive tests. The anatomy of normal structures and pathologic processes is more easily recognized so that appropriate conservative or surgical therapy can be instituted.

High resolution computerized tomography is now the primary diagnostic modality for demonstrating pathology in the lumbar spine.[1] Advantages include: (1) increased diagnostic accuracy; (2) decreased risk and discomfort to the patient when compared to other studies; (3) reduced incidence of failed back surgery syndrome; and (4) cost effectiveness. The last can be attributed to a reduced need for other studies (*i.e.*, myelography, discography and epidural venography) and routine performance on an out-patient basis.

An estimated 80% of adults have a history of low back pain. Most of these persons recover quickly but almost 50% go on to recurring pain syndromes. In the U.S., low back pain is second only to upper respiratory infection as a cause for work absenteeism. It is the most costly type of worker's compensation disability.[2]

Customary examinations of the lumbar spine (radiography, tomography, myelography, electromyography, discography and epidural venography) all have limitations in revealing the full spectrum of anatomy and disease processes, either individually or collectively performed. Especially with regard to the spinal cord and nerve roots, all methods are indirect. It was not until the advent of high resolution computerized tomography that the cord and nerves and their relationships to surrounding bony and soft tissue structures could be directly visualized.

The newer high resolution scanners can demonstrate structures less than 1mm in diameter. In the lumbar area, epidural fat surrounding the nerves and dural sac provides a natural contrast agent so that introduction of other agents is not usually necessary.

Since September, 1980, we have performed approximately 4000 scans of the lumbar spine. The scan routinely includes 5mm consecutive sections from mid L3 through S1. A preliminary scout view is first obtained and the desired sections are

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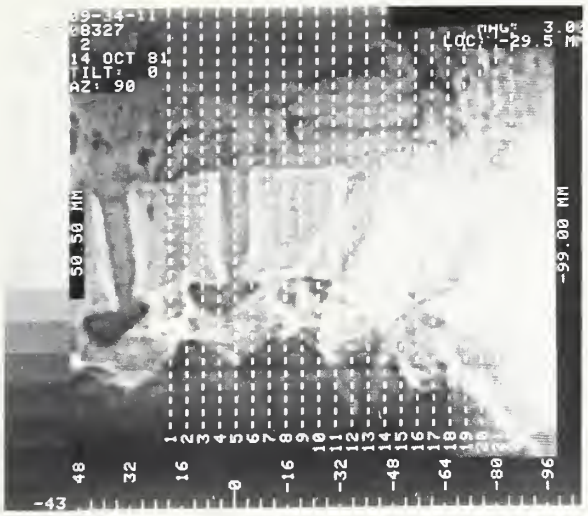


Figure 1
Preliminary scout view. Computer is programmed for 5mm thick images. Additional angled images of the disc spaces also obtained (not shown).

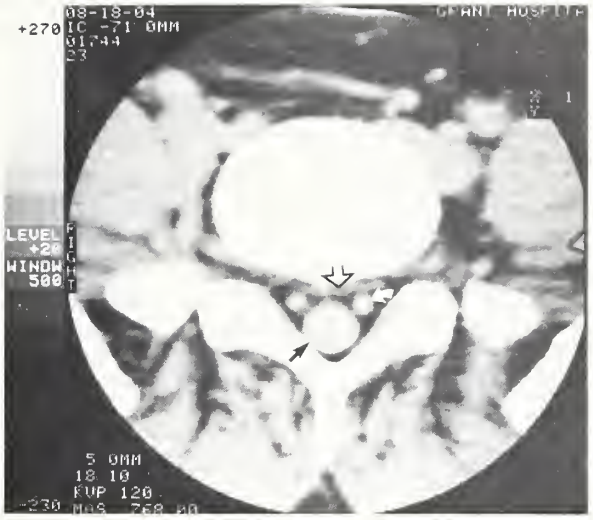


Figure 2
Normal axial image of L5-S1 intervertebral disc space showing dural sac (black arrow) surrounded by epidural fat, S1 nerve roots (curved white arrow) and venous plexus (open arrow).

programmed (Figure 1). The cross-sectional or axial images are optimal for demonstration of the dural sac, nerve roots and surrounding structures (Figure 2). At times computer reconstructions in the sagittal, oblique and coronal planes are also useful.

Initially in our experience, cases were confirmed with myelography prior to surgery. Correlation was good and consistent. Recent studies have also borne out this experience. W. Sachsenheimer, *et al,* reported on a series of 36 operatively verified cases of lumbar disc herniation that had both C.T. scans and myelography. Computerized tomography correctly diagnosed 35 of these cases while myelography diagnosed 31 cases. In the differentiation between lateral and medial discs, C.T. was correct in 33 and myelography in 27.[3] Haughton, *et al.,* reported on 52 patients who had explorations. Of these, 46 C.T. and 44 myelographic diagnoses agreed perfectly with the operative diagnoses. C.T. demonstrates lumbar disc lesions as effectively as myelography.[4] Our neurosurgeons now feel that in most cases myelography is redundant. They are willing to perform surgery on the basis of C.T. demonstration of herniated intervertebral disc provided that there is appropriate symptomatology.

Herniated intervertebral discs (Figure 3) are readily recognized by their encroachment or obliteration of epidural fat and displacement of normal nerve roots.[5,6] Attenuation values for intervertebral discs are higher than those of nerve tissue, which helps in the differentiation of these tissues. Frequently, bony abnormalities rather than disc problems are responsible for symptoms. CT scans are ideally suited for demonstrating pathology related to the apophyseal joints, neural canals, bony spinal canal and surrounding paraspinal region.[7] Spinal stenosis can readily be identified (Figure 4). Other pathologic processes including neoplasms, infection and fractures are also demonstrated to advantage with CT.

It is estimated that 25-35% of post-surgical patients continue to complain of back pain. Many times the so-called failed back surgery syndrome is the result of incomplete pre-operative understanding of the pathology.[8] Since CT allows direct visualization of structures, inferences from indirect techniques are no longer necessary. Presurgical evaluations can be more exact and lead to appropriate surgical approach.

Limitations Noted

C.T.'s most serious limitation is in evaluation of the postoperative spine. Fibrosis often obscures the contents of the canal completely and makes separation of structures impossible. Density discrimination is not yet fine enough in most cases to differentiate between hematomas, infections or simply edematous tissues in the early post-op

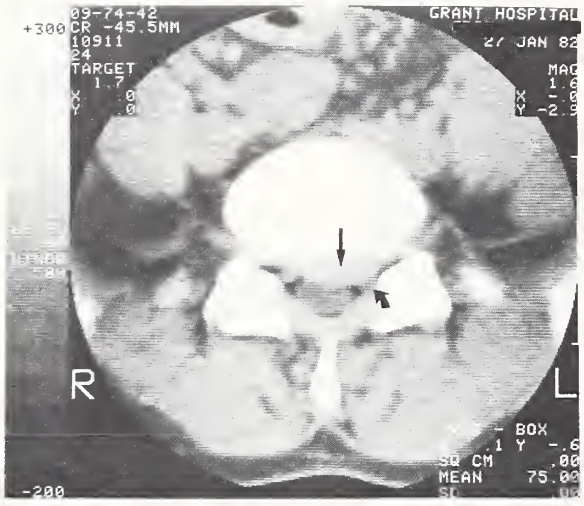


Figure 3
Herniated intervertebral disc (straight arrow) at L5-S1 level encroaching on epidural fat and dural sac. Left S1 nerve root (curved arrow) is displaced posteriorly and flattened. Attenuation number of 75 consistent with disc (cursor).



Figure 4
Lateral bony spinal stenosis secondary to marked degenerative hypertrophic changes of left facet joint.

period and between recurrent disc herniation and fibrosis in the late post-op period.

Limitations also exist in severely scoliotic patients, where two different levels of the vertebral body are seen on each scan. In very obese patients, there is significant degradation of the images by artifacts.

C.T. occupies only an ancillary role in the diagnosis of intradural lesions, including arachnoiditis. Myelography remains the primary radiographic tool in these lesions. C.T. may suggest the presence of such lesions, however; intravenous contrast injection or intrathecal amipaque may demonstrate them to good advantage. Often, additional information will be obtained, especially if there is lateral extension of the tumor or bone destruction.

An analysis of costs related to the work up of low back pain indicates that C.T. is definitely cost effective. When the costs of hospitalization and associated X-ray and laboratory testing simply related to the diagnosis of herniated intervertebral disc are calculated, they far exceed the cost of an out-patient C.T. scan of the spine.

Summary

High resolution computerized tomography clearly demonstrates the structures of the lumbar spine without discomfort or risk to the patient. Neither hospitalization nor invasive testing are necessary. Lumbar disc herniations as well as degenerative changes involving the intervertebral articulations and zygoapophyseal joints, spinal stenosis, neoplasm, infection and fractures are all readily recognizable. With improved diagnosis, appropriate conservative or surgical therapy can be selected on a more rational basis. Hopefully, the incidence of failed back surgery will be reduced. Computerized tomography has become the primary diagnostic study for low back pain.

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Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR, M.D., CONTRIBUTING EDITORS

Radiation-Induced Breast Cancer

Surgical Grand Rounds are held weekly on Tuesdays, 5:00 pm in the Offield Auditorium of the Passavant Pavilion, Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 25, 1982.

Dr. Garth Ballantyne: The patient is a 21-year-old white woman who was admitted for treatment of inflammatory carcinoma of the right breast. Her pertinent medical history had begun when she was nine years old. At that time, the patient was discovered to have a posterior mediastinal mass. A right thoracotomy was performed but the lesion was not resectable. Biopsy revealed a mixed ganglioneuroma and ganglioneuroblastoma. The patient was treated with radiotherapy and received 17 fractions of Cobalt 60 for a total dose of 4,000 rads. Subsequently, she developed a right Horner's syndrome and right upper lobe fibrosis. At puberty four or five years later, the right breast failed to develop normally and remained hypoplastic.

Because the right hypoplastic breast had poor cosmetic effect a right breast augmentation was performed when she was 15 years old. A silicon implant was placed through a right inframammary fold incision and the cosmetic effect was satisfactory.

She did well until she became pregnant. During the third trimester of her pregnancy, she noticed some increased firmness of her right breast. The patient had an uncomplicated delivery. She was able to nurse the baby with both breasts but noticed, within ten weeks, tenderness and induration of the right breast with some periareolar ecchymosis. Her physician recommended that she stop nursing the baby and gave her medication to suppress the lactation. She was evaluated at another hospital five months after delivery.

Physical examination revealed an edematous indurated breast without discreet masses. She had marked lymphadenopathy with fixed lymph nodes in both the right axilla and the right supraclavicular region. The clinical impression was inflammatory breast carcinoma. Mammography revealed an ill-defined ovoid mass which contained punctate calcifications. In addition, there was thickened skin over the lesion. Biopsy revealed an infiltrating carcinoma. Liver-spleen scan was normal. The bone scan suggested some increased uptake in the right acromial region and in the bodies of T3 and T4. X-rays of those areas did not demonstrate lytic lesions.

The patient was then transferred to this hospital with a diagnosis of inflammatory breast carcinoma. She was told of the poor prognosis for her disease but agreed to an aggressive therapeutic course. The right breast was radiated through medial and lateral tangential ports for 25 fractions for a total of 4,000 rads. The lymph bearing regions were radiated through anterior and posterior fields with 25

fractions for a total of 5,000 rads. Chemotherapy was initiated after the radiation therapy and included methotrexate, cytoxan, 5FU and prednisone. In addition, hormonal therapy was begun with tamoxifen. There was an objective favorable response to therapy. Radiotherapy was completed in five months and after one month of chemotherapy, a right total mastectomy was performed. Pathological examination demonstrated infiltrating ductal carcinoma with subdermal involvement of the lymphatics compatible with the clinical diagnosis of inflammatory breast carcinoma.

Radiology: The liver spleen scan on this patient is normal. The liver is normal in size and the spleen is not enlarged. There is no evidence of metastatic disease. Her chest X-ray just prior to surgery shows evidence of the previous radiation. There is an air bronchogram where you can see retraction of the right hilum and tenting of the diaphragm. The trachea is pulled over a little to the right. These are signs of volume loss from chronic scarring and fibrosis. A chest film from two years ago is practically identical. A film of her right shoulder was taken because of the bone scan and is normal.

Pathology: The breast was about 20cm in diameter. Microscopically, there was classical infiltrating ductal carcinoma. The deep lymphatics were involved. Examination of sections from the nipple show that the lymphatics are permeated by carcinoma. The superficial lymphatics, in every part of the skin examined, contain carcinoma. This is dermolymphatic carcinomatosis and is equated with a very poor prognosis.

Dr. Garth Ballantyne: There are several features of this patient's problem which are distinctively unusual. First, the development of breast carcinoma at the age of 21 is uncommon. Haagensen studied 6,000 women with breast carcinoma at the Columbia-Presbyterian Medical Center during the 50 year period from 1916 to 1966. He found that only 0.2% in his study were below the age of 25 years. He cited a similar study from Denmark in 1965 and stated that the risk of developing carcinoma of the breast before the age of 25 years is negligible.

A second unusual feature is the development of breast carcinoma in a pregnant woman. In Haagensen's 50 year study from the Columbia-Presbyterian Medical Center, 71 pregnant or lactating women were found to have breast carcinomas. Their average age reflected their childbearing period. Symptoms appeared about 12 months before diagnosis of the lesion. Unfortunately, nearly 50% of the women were found to be inoperable at the time of diagnosis. If a woman had a Columbia Stage I, a ten year survival of 60% was reported. However, the average survival for the entire group was only 16%, reflecting the late stage at the time of diagnosis.

A third unusual feature of this patient's presentation was the presence of inflammatory breast carcinoma which is reported to occur in less than 2% of patients with breast cancer. The Columbia-Presbyterian series included only 87 cases of inflammatory breast carcinoma. Survival was poor with the mean survival of these 87 patients only 19 months.

An important factor in the development of breast cancer in the present patient was the radiation therapy that she received at the age of nine years. There is evidence that exposure to radiation increases the incidence of breast carcinoma. Breast cancer has developed in the mammary glands of mice, rats and guinea pigs which received chronic irradiation with radium or X-rays. Approximately 50% of the exposed animals developed either breast carcinomas or breast sarcomas. In experimental models, using rats, a dose-response relationship could be demonstrated. In addition, exposure to an atomic blast tripled the incidence of mammary carcinoma in mice.

Studies of patients exposed to radiation under a variety of circumstances have shown a relationship between breast cancer and radiation exposure. In the past, post-partum mastitis was treated with radiation. The incidence of breast cancer in such patients increased in nearly linear fashion to 400 rads. Another group of patients was studied that had been confined to sanitaria with pulmonary tuberculosis. They were treated with controlled pneumothorax and followed with multiple fluoroscopic examinations. Follow-up studies from two Massachusetts sanitaria demonstrated a relationship between radiation exposure and breast cancer over a 20 year period. There was a nearly linear response curve up to 600 rads, at which level approximately 400 cases of breast cancer per 100,000 women were estimated.

The atomic blasts in Japan at the end of World War II provided another opportunity to study the effect of radiation on the incidence of breast cancer. The exposure of women to radiation could be estimated from their distance to the center of the blast. The incidence of breast cancer had a linear relationship to increasing exposure. At 600 rads, there were nearly 200 cases of breast carcinoma per 100,000 women per year. These three groups of patients provide strong evidence that the incidence of breast cancer is increased by exposure to external irradiation. When age was considered, it became apparent that young patients were at greater risk.

Additional patients have been reported who had hypoplastic breasts following radiation and developed breast carcinoma. At the time of their expo-

sure to radiation, they were treated for Wilm's tumor, hemangioma of the right breast and mediastinal lymphoma. The average interval between radiation and the appearance of breast cancer was 17 years in these patients. From these studies, it has been concluded that age, at the time of irradiation, is a major parameter of risk and that women irradiated during adolescence have a higher risk of radiation-induced breast cancer than those irradiated when older.

Dr. Beal: This patient obviously presented a very difficult problem and treatment. Consultations were obtained from the departments of radiation therapy and medical oncology. Dr. Merrill Kies will discuss patient management.

Dr. Merrill Kies: I will discuss the treatment of metastatic breast cancer.

This patient has a very aggressive disease by clinical and histologic criteria. We are unquestionably dealing with a patient with metastatic disease. Metastatic breast cancer, unlike a number of other malignancies that respond well to chemotherapy, is virtually never cured with chemotherapy as we use it today. Presently there are a number of different regimens, but no one regimen has been demonstrated to be markedly superior to others. The most commonly used agents have been cytoxan, methotrexate, 5FU and prednisone. A more aggressive three-drug program utilizes adriamycin with cytoxan and 5FU in a variety of dose schedules. The results remain about the same. Across the country, remission rates are very respectable, in the 50% to 80% range, but complete response rates (elimination of all clinical radiologic evidence of disease) are very low. This is in contrast to testicular carcinoma, Hodgkin's disease and childhood leukemia, where chemotherapy may result in cure. With the currently available chemotherapy programs for breast cancer, the median survival for responding patients is about 2-3 years and for non-responding patients, only about 18 months. Obviously, this is far from an acceptable situation.

We need a better understanding of cancer biology and more active drugs. Currently, the advances in these areas are slow. However, even without a major advance in the understanding of cancer biology, there exists a potential improvement in current therapy by looking carefully at scheduling and drug selection, and at increased intensity of therapy. This latter is an area that I would like to discuss in more depth.

Improvement in cancer treatment, for example, Hodgkin's disease, has occurred with combinations of active drugs with non-overlapping toxicities, *i.e.*, MOPP. This has resulted in cure for a substantial percentage of patients who had otherwise been thought to be untreatable. Dose seems to be a critical factor in the treatment of a number of metastatic cancers. Lower doses are certainly appealing in ambulatory care. Doctors as well as patients dislike arduous courses of therapy that result in hair loss, loss of platelets, malnutrition, and other undesirable side effects. But few studies have examined the importance of dose in the drug treatment of breast carcinoma. In animal systems, increasing single doses of chemotherapy unquestionably result in higher percentages of elimination of experimental tumors.

In humans, there is a corollary in Hodgkin's disease, a neoplasm that is exquisitely sensitive to chemotherapy and to radiation. It has been demonstrated that by increasing dosage to an acceptable level, the rate of sterilization of involved lymph nodes increases to nearly 100% control. A dose response effect has been shown in acute leukemia in adults as well. The Seattle group demonstrated that of those patients who relapse, 10-15% appear to have long-term disease-free survival and are possibly cured after intensive combined radiation/chemotherapy treatments. Treating adults with acute leukemia in remission, (not relapse) with virtually the same approach of intensive combined radiation/chemotherapy treatment, resulted in a long-term disease free survival rate in excess of 60%.

We are now testing another concept, which was formulated only a few years ago. We can take autologous marrow from breast cancer patients and use it to support them through the periods of marrow suppression after intensive radiation and chemotherapy treatments. Would this make a difference? Certainly it is a more feasible program for selected patients. Because this method employs autologous bone marrow, tissue incompatibility is not a problem. Developing effective therapy, of course, is the largest obstacle we face, even with intensive chemotherapy or intensive chemotherapy/radiation therapy combined approach. The use of autologous bone marrow transplant depends on the concept that the limiting toxicity of chemotherapy is primarily marrow suppression. If we rescue the marrow and the patient is suffering from major lung toxicity, for example, nothing is gained. This method might be considered in this 21-year-old woman who is unlikely to survive more than 18 months with conventional therapy. We consider it reasonable to use intensive combined radiation/chemotherapy in certain selected patients where conventional treatment has failed.

Bone marrow harvest involves taking about one liter of marrow. We separate the red cells and give them back to the patient. The patient has the procedure under general anesthesia and despite multiple punctures, usually tolerates this procedure

very well. Harvesting the marrow has become, in our clinic, a relatively minor problem compared to the rigours that accompany intensive chemotherapy or chemotherapy/radiation therapy. Prolonged periods of myelo suppression, thrombocytopenia and nutritive deficits frequently result. The success of bone marrow transplant therapy rests on having a marrow free of tumor and not severely damaged by prior cytotoxic and/or radiation therapy. That is something that we address in evaluating these patients individually.

This patient will be treated with combination chemotherapy. If she responds favorably, consideration will be given to experimental high dose therapy with autologous marrow support.

Dr. Beal: Although this patient had radiation-induced breast cancer, she responded quite well to the radiation. The tumor became smaller and the skin more pliable. The mastectomy was performed without technical problems. We have had similar experience with inflammatory breast cancer, not radiation-induced. In 1974, we treated a patient, with inflammatory breast cancer, with radiation followed by mastectomy and intensive chemotherapy. She survived eight years but ultimately succumbed to her disease.

Dr. Ballantyne has emphasized the important points regarding breast cancer following irradiation of the breast. In *Cancer,* in 1977, there was an interesting article on breast cancer following irradiation of the breast. This was a Scandanavian report which involved more than 1,000 women treated with radiation for various types of non-neoplastic conditions of the breast. Thirteen of these patients were young women who had received radiation for unilateral breast hypertrophy. As a result, they had a controlled study. The patients had an untreated breast and a treated breast. A much larger number of cancers developed in the treated breast, when compared with the non-radiated breast. From that study, they concluded that the median latent period for cancer developing in a previous radiated breast was about 24 years. They found, as Dr. Ballantyne mentioned, that patients who had been irradiated at a lower age ran a considerably higher risk of developing breast cancer. There was an apparent shortening of the latent period as the dose ranges for the radiation increased.

Bibliography

Bibliographical information may be obtained by writing the Illinois Medical Journal, *55 E. Monroe, Suite 3510, Chicago, IL 60603.*

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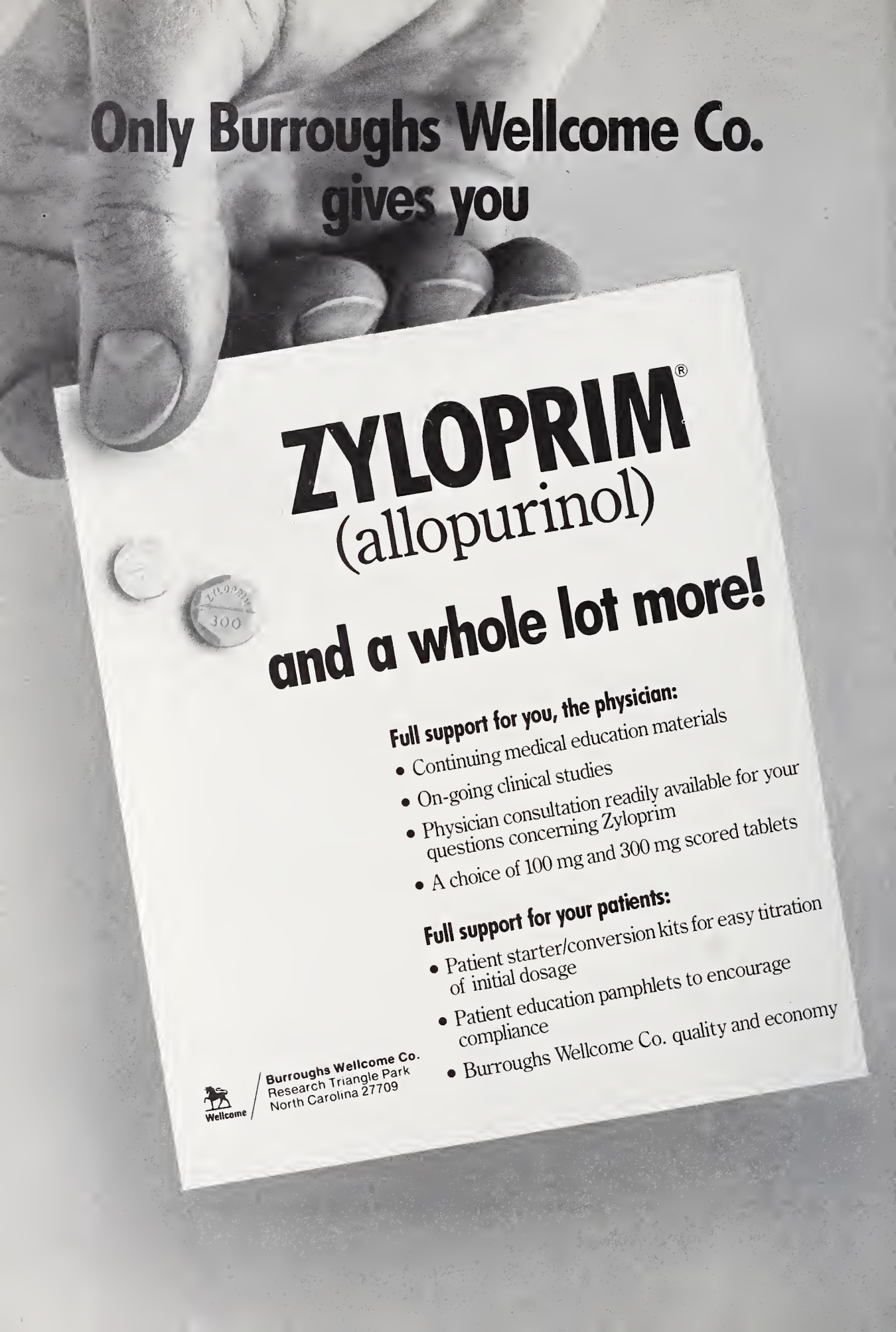
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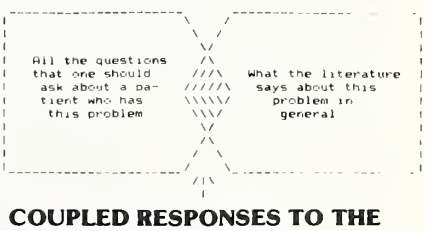
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This is the third in a series of articles prepared under the direction of the ISMS Sports Medicine Committee that will focus upon clinical sports medicine topics and related issues. The series is intended to broaden clinical knowledge, aid the physician in educating patients on preventive measures and, hopefully, stimulate physician involvement in activities designed to protect the health of young athletes. The Committee welcomes your comments and suggestions.

Exercise and Asthma in Athletes

By Henry J. Dold, M.D./Arlington Heights

Physicians have known for centuries that certain forms of exercise may initiate respiratory difficulty in some individuals, yet it is only in the past few decades that the concept of exercise-induced asthma (EIA) has been more precisely delineated.[1-3] The increased attention directed toward this entity is due, in part, to our increased understanding of airway pathophysiology and how bronchoactive drugs might be utilized.[4] The apparent increased incidence of EIA may be due to the renewed emphasis on physical fitness programs in our schools and to the increased popularity of running as a form of exercise in our health-conscious society.

The intent of this review is to point out salient features of EIA to aid physicians and others engaged in exercise, conditioning or physical education programs in identifying and managing the asthma-prone athlete.

EIA may be defined as an abnormal response to exercise in susceptible individuals, manifested by a fall in peak expiratory flow rate (PEFR) or in forced expiratory volume in one second (FEV_1) greater than 10%-15% from pre-exercise levels. Associated signs of airflow obstruction include wheezing and shortness of breath.[5] This response to exercise is uniquely different from the response seen in the non-asthmatic and follows a characteristic pattern. Exercise for one minute to two minutes produces slight increases in expiratory flow rates. Following this transient bronchodilatation, there is a steady decline in flow rates, beginning 3-5 minutes after initiating the exercise, reaching a peak 5-10 minutes after completion of exercise, with recovery to pre-exercise levels over the next 30-90 minutes.[6]

EIA is an entity specific for asthmatics or those with latent asthmatic tendencies. It may also be seen in patients with clinical evidence of allergic rhinitis. The condition is generally absent in non-atopic individuals and in patients with other lower respiratory problems, such as cystic fibrosis or tuberculosis.

Exercise is a common bronchospastic triggering mechanism in the asthmatic population. In a study of 652 adults and children, 81% of these clinically recognized asthmatics had a post-exercise fall in PEFR compatible with the definition of EIA.[7] Another investigation revealed that up to 85% of patients with methacholine-induced bronchospasm exhibited EIA after exercise provocation, while this abnormal response to exercise was absent in patients with negative methacholine challenge.

This bronchoconstrictive response to exercise must be distinguished from exercise-induced anaphylaxis, an infrequently encountered, although potentially life-threatening entity, manifested by development of exercise-associated urticaria, hives, general angioedema, respiratory distress,

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abdominal pain and syncope.[8]

Investigations have elucidated some notable clinical features of EIA. One study confirmed the frequent observation that different modes of exercise, when performed at similar work levels, *i.e.*, similar oxygen consumption rates, produced varying degrees of asthma. Running caused the most bronchoconstriction, cycling less, walking even less, and swimming little.[9]

Next, as the duration of a particular exercise was increased the degree of post-exercise bronchospasm also increased up to 6-8 minutes, after which there was no further increase in asthma. In fact, some patients who continued to exercise beyond this point experienced less bronchospasm than if they exercised for shorter periods. This confirmed another clinical observation: some individuals "run through" their asthma with continued exercise.

Another study demonstrated that exercising at 65% of maximum working capacity for 6-8 minutes was sufficient to produce the maximum amount of bronchospasm and establish diagnosis. Less intense efforts for shorter periods caused proportionately less asthma.

Performing the same exercise with varying rest intervals between the efforts caused varying effects in flow rates. Bronchospasm tended to be less severe when one exercise period followed another with time intervals of less than one hour. Bronchospasm could be significantly reduced if an exercise was repeated during an appropriate "refractory period."[10]

For years, discussing the pathogenesis of EIA meant evaluating parameters such as the nature, severity and duration of specific exercises as modalities in initiating bronchoconstriction. As bronchodilator research progressed, the pharmacological actions of chemical mediators and of various therapeutic agents were incorporated into a working hypothesis. Thus, the initial bronchodilatation observed early in exercise was attributed to endogenous catecholamine. With continued exercise other mediators that initiated bronchoconstriction were released. For the next few minutes there was essentially a balance between these chemicals with no appreciable changes in flow rate parameters. As exercise continued, catecholamine levels returned to baseline, which allowed the bronchospastic component to become apparent. The "refractory period" suggested that a time interval was needed to resynthesize mediators. In some individuals, mediators became "exhausted" if the exercise was continued and the bronchospasm eased, allowing one to "run through" the asthma. The effects on EIA of various bronchodilating agents confirmed this theory.[1] The "mediator hypothesis" was given further credence when sodium cromolyn was found effective in aborting EIA. When given up to one minute before exercise, this non-bronchodilator was thought to prevent asthma by stabilizing mast cells from releasing mediators.[11]

The validity of this hypothesis was later challenged by others, who found that many of the early test results could be significantly modified simply by asking the subjects to breathe humid air during the procedure. Subsequent studies followed, examining the effects of respiratory membrane heat and water exchange on airway function during exercise. Breathing dry, cold air was found sufficient to provoke bronchospasm, either by direct cooling of bronchial musculature and/or nonspecific release of mediators from bronchial mast cells.[12,13] If this "heat exchange" theory were valid, it should be possible to duplicate the flow rate changes caused by exercise through simple voluntary hyperventilation, and, in fact, this was seen.[14]

Despite the somewhat confused state as to mechanisms involved in EIA, physicians and sports-medicine related personnel are still faced with the daily problem of asthma prophylaxis in these patients. Identifying individuals with this condition is the critical step needed before any management can be considered. Coaches and other non-medical sports personnel should be familiar with the entity of EIA. It is not unusual for a coach to observe a patient performing well in certain exercises or sports drills, only to have difficulty during "conditioning laps." Too often the tendency is to blame such submaximal performance on lack of motivation. When questioned, the patient may deny having asthma, stating that he wheezes "only when he runs." Indeed, while some athletes learn how to play "hurt," the EIA-prone athlete often learns to play "short of breath." Eventually, in most instances, continued inability to participate fully in certain activities without respiratory difficulty will be questioned by the patient or his family and the EIA problem will surface.

Once an exercise-induced problem has been identified, there are some initial measures which may minimize adverse effects precipitated by the patient's activities. First, EIA can be greatly modified by the choice of proper exercises or sport for the patient. Substantially less dyspnea occurs in sprinters, baseball players or swimmers than in cross-country runners, basketball or soccer players or participants in other non-rest sports. The EIA patient should avoid outdoor activities such as ice skating and skiing in extremely cold weather, as wind-chill factors potentiate the tem-

perature factor. Unless essential to performance, sports practices and drills should be held indoors during inclement weather. These individuals should defer most strenous workouts, even if held indoors, if they are already symptomatic due to pre-existing bronchospasm, whatever the source.

Instructing patients to inspire through the nose is a simple expedient which alone will often minimize bronchoconstriction due to the warming and humidifying action of the nasal mucosa.[15] In a similar manner, the use of a cold weather face mask may control cold air-associated respiratory symptoms and allow outdoor activities.[16]

If the above measures are inadequate or incomplete in controlling symptoms, appropriate pharmacologic agents should be employed. A number of drugs have been shown to prevent or alleviate EIA if taken prior to the provoking physical exercise.[17] Most notable are the beta-sympathomimetic agents, such as isoproterenol, isoetharine, metaproterenol, terbutaline and albuterol. Their relative lack of side effects, along with convenient administration and rapid action, especially in aerosol form, have led to increased use of these drugs in the EIA-prone patient. In general, inhaled compounds provide better protection than the oral preparations. In aerosol form, these agents have the advantage of ready availability for use in unplanned activities and remain bio-effective up to four hours or more. The ability to administer the drugs covertly is also helpful for the patient who does not wish to draw attention to his need for pre-exercise medication. When comparing degree of control and length of action, albuterol has been shown the most effective of this class of drugs. For the younger patient, liquid preparations of metaproterenol are available; terbutaline and albuterol are presently not approved for use by patients under 12 years of age.

Methylxanthines, such as theophylline and its cogeners, also provide consistent protection from EIA if taken 30-60 minutes before exercise in a dose sufficient to attain therapeutic serum levels.[18,19] Unfortunately, unless a patient is on maintenance theophylline therapy, the need for relatively high doses of this drug prior to exercise frequently causes unwanted side effects, which in turn results in poor patient compliance. In general, theophylline appears less effective in EIA than the sympathomimetic agents. A distinct advantage of theophylline in EIA, however, is its potential for long periods of protection, up to twelve hours with sustained release preparations. This may be an important consideration in prolonged or intermittent exercise activities or when the exact time or nature of an activity cannot always be anticipated.

Sodium cromolyn by inhalation has been reported to effectively prevent EIA in a majority of patients, even if taken up to one minute before the exercise.[19,20] Its effects may last up to six hours. Unlike the methylxanthines there is no need to take sodium cromolyn on a continuous basis.

If the use of beta-sympathomimetics, methylxanthines or sodium cromolyn fail to control EIA, these agents can be combined for added effect.[21] Some patients may also benefit from a post-exercise dose of the sympathomimetics or theophylline. Sodium cromolyn is ineffective if taken at the termination of exercise.

Anticholinergic agents such as atropine and its synthetic analog, ipatropium, have successfully blocked EIA, but these drugs may have undesirable side effects and are not approved for this use in this country.[22,23]

Other medications with inconsistent or negligible effects in EIA include antihistamines and both systemic and inhaled corticosteroids.[1]

The efficacy of calcium ion antagonists in EIA has not been clearly established.[24]

When appropriate, the team physician must inquire as to whether a participant's use of any medication in an athletic event violates the rules of the sponsoring organization.

Conclusion

Physicians and others concerned with physical fitness or athletic programs must be knowledgeable of EIA, especially with respect to its detection. Although wheezing is the most prominent clinical feature, some patients experience only a cough or complain of dyspnea. Inadequate physical participation or submaximal performance should not automatically be interpreted as lack of interest in the pre-adolescent, or poor motivation in the teenage athlete, or to deteriorating physical conditioning in the adult.

Because of prior attempts at exercise or of ongoing asthmatic symptoms, many patients have learned to avoid forms of exercise which have triggered breathing problems, effectively excluding themselves from strenuous physical activity. In these individuals, unless adequate counseling, encouragement and medical management are provided early in a conditioning program, unnecessary psychological pressures may be generated—not only in the patient but in parents, peers and teachers. Efforts at continuing the program may prove self-defeating.

Since EIA is a condition frequently encountered by asthmatics, some of these patients may be symptomatic prior to exercise. Control of allergic

nasal and chest symptoms is paramount before initiating any exercise program.

The importance of recognizing and controlling EIA cannot be overemphasized. Physicians should encourage proper physical conditioning in all their patients and help them attain reasonable goals. They should resist the tendency to excuse students from physical education or competitive sports without cause or to discourage adults from remaining physically active. ◀

Acknowledgement

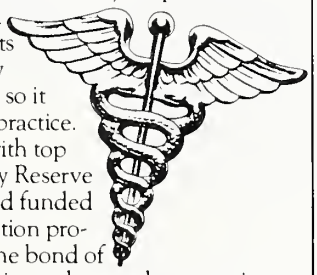
I am indebted to my associate, Robert J. Hart, M.D., for his helpful comments throughout the preparation of this article.

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A complete list of references for "Exercise and Asthma in Athletes," may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago IL 60603.

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****Bellizzi, Alfred,** Oak Park, died May 21, 1983 at the age of 89. Dr. Bellizzi was a 1921 graduate of *Facolta di Medicina e Chirugia dell'University di Napoli,* Italy.

***Faulk, Elliott,** Mendota, died April 26, 1983 at the age of 70. Dr. Faulk was a 1937 graduate of *Faculte de Medecine de l'Universite de Paris,* France.

****Faulkner, George E.,** Joliet, died June 6, 1983 at the age of 87. Dr. Faulkner was a 1925 graduate of the Jefferson Medical College of Thomas Jefferson University, Philadelphia.

***Fielding, Robert T.,** Hinsdale, died May 25, 1983 at the age of 70. Dr. Fielding was a 1939 graduate of the New York Medical College, New York.

***Gajewski, Chester J.,** Oak Park, died May 31, 1983 at the age of 64. Dr. Gajewski was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Gray, Edward W.,** Chicago, died June 3, 1983 at the age of 67. Dr. Gray was a 1939 graduate of the University of Chicago Pritzker School of Medicine.

***Klein, Erwin, I.,** Lombard, died December 9, 1982 at the age of 59. Dr. Klein was a 1950 graduate of *Medizinisch Fakultat der Ludwig Maximillams-Universitat,* Muchen, Bayern, Germany.

***McGoey, Joseph P.,** Springfield, died June 20, 1983 at the age of 73. Dr. McGoey was a 1938 graduate of Loyola University Stritch School of Medicine, Maywood.

****Stack, James K.,** Chicago, died June 8, 1983 at the age of 79. Dr. Stack was a 1931 graduate of Northwestern University Medical School, Chicago.

***Sulek, Arthur E.,** Rockford, died June 7, 1983 at the age of 72. Dr. Sulek was a 1936 graduate of the University of Iowa College of Medicine, Iowa City.

****Walsh, Eugene L.,** Glenview, died June 9, 1983 at the age of 78. Dr. Walsh was a 1931 graduate of Northwestern University Medical School, Chicago.

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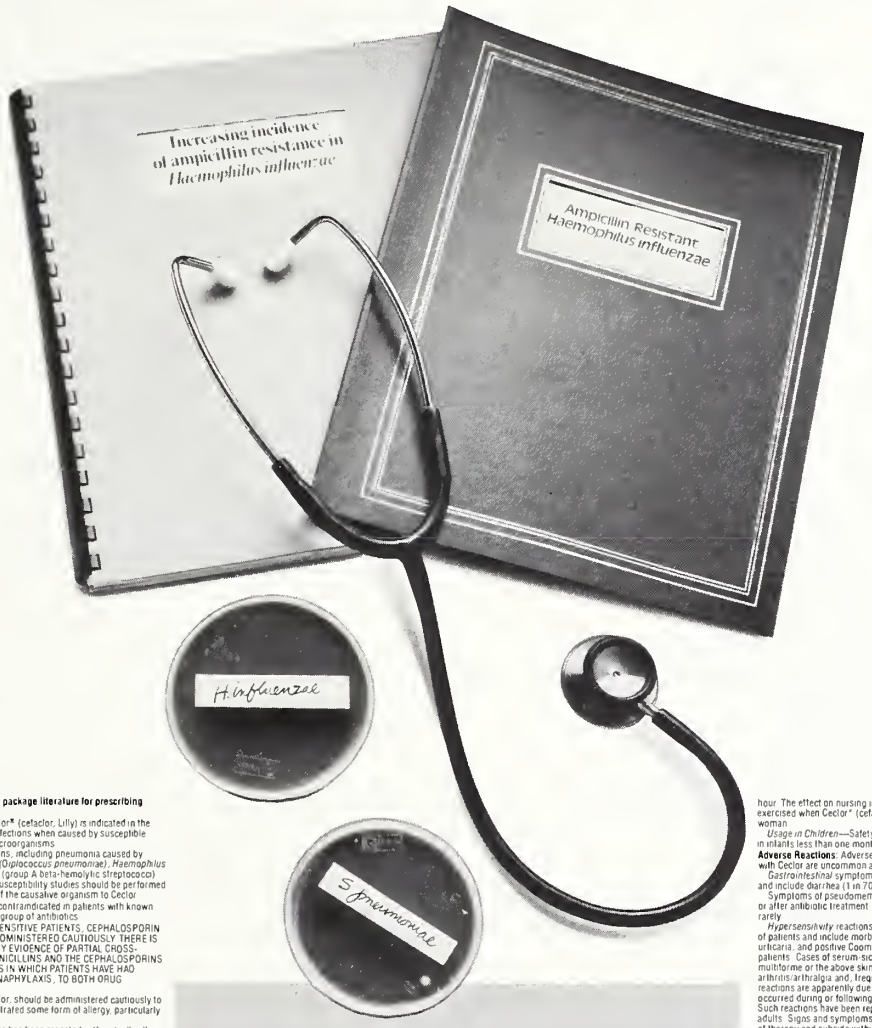
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Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mothers' milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*: 91, 1975.
2. Antimicrob. Agents Chemother., *11*: 470, 1977.
3. Antimicrob. Agents Chemother., *13*: 584, 1978.
4. Antimicrob. Agents Chemother., *12*: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Doctor's News

PHYSICIANS IN THE NEWS—**Frank J. Jirka, Jr. M.D.,** Barrington Hills, was installed as president of the American Medical Association at the climax of the AMA annual meeting last month. In a second exciting event for Illinois, ISMS first district trustee, **John J. Ring, M.D.,** Mundelein, was elected a trustee of the AMA on the first ballot.

Other elections at the AMA Annual Meeting included: **Ira R. Friedlander, M.D.,** Chicago, re-elected to the Council on Scientific Affairs; **Ronald Davis, M.D.,** Chicago, elected AMA/RPS alternate delegate to the AMA House of Delegates; **Malcolm Major,** Chicago, elected AMA/MSS alternate delegate to the AMA House of Delegates and **Sandra Olson, M.D.,** Chicago, named to the Hospital Medical Staff Section governing council.

Joseph C. Sherrick, M.D., Chicago, former ISMS third district trustee, hosted the first nationwide satellite symposium in laboratory medicine. The symposium, "New and Future Procedures in Laboratory Testing," was transmitted from New York to 31 sites including Chicago.

Two physicians recently elected to fellowship in the American College of Physicians were **Terry Frakes, M.D.,** Rockford and **Donald F. Pochyly, M.D.,** River Forest.

Gerald Downie, M.D., Kankakee, was recently awarded the ISMS Auxiliary Humanitarian Award in the non-member category for his 50 years of medical missionary work.

Arthur H. Rubenstein, M.D., Chicago, recently received the Banting Medal, the highest scientific award given by the American Diabetes Association. Dr. Rubenstein was honored with the award for his outstanding accomplishments in the field of diabetes research.

Herbert Kaizer, M.D., Chicago, has been appointed director of the Bone Marrow Transplant Center at Rush-Presbyterian-St. Luke's Medical Center.

Recently elected to the Illinois Academy of Family Physicians at their 35th annual meeting were: **Mack Hollowell, M.D.,** Charleston, president; **Delbert Harris, M.D.,** Lebanon, chairman of the board; **Robert Swastek, M.D.,** Chicago, president-elect; **Joe W. Cannon, M.D.,** Lacon, vice president; **Lawrence L. Hirsch, M.D.,** Chicago, national delegate to the American Academy of Family Physicians; **Harry Marchmont-Robinson, M.D.,** Chicago, alternate delegate from Illinois to the American Academy of Family Physicians; **Lawrence Plummer, M.D.,** Jerseyville, speaker of the congress of delegates; and Lee Sacks, M.D., Niles, member of the board of directors.

Frank B. Norbury, M.D., Jacksonville, has been elected governor-elect of the American College of Physicians.

Robert W. Wissler, M.D., Chicago, won the Gold Headed Cane Award of the American Association of Pathologists in recognition of his contributions to the field of pathology.

DISABILITY CLAIMS ELIGIBLE FOR REVIEW—The social security administration will review certain disability claims in Illinois, Indiana, Ohio, Michigan, Minnesota and Wisconsin where individuals with mental impairments were either denied disability benefits or terminated from the disability rolls. Qualifying for review are persons between the ages of 18 and 49 who were denied social security disability benefits or supplemental security income disability benefits, or individuals whose disability benefits were terminated from March 1, 1981 to January 4, 1983, inclusive, who alleged a mental impairment (other than mental retardation). Anyone who knows or represents an individual who meets these requirements may contact their local social security office to obtain further information.

CHILD HEALTH SEMINARS—Physicians are invited to attend two child health educational programs, co-sponsored by ISMS, in September. The Child Passenger Safety Conference will be held September 9-10 in Springfield. The statewide conference will cover topics such as behavior modification to encourage children to use car seats.

The second program, "Impact of Lifestyles on Child and Adolescent Health Problems," will be held September 10-11 at the Hyatt Regency Hotel, Chicago. Seminar topics will focus on prevention and treatment of problems resulting from such environmental influences as child abuse, drug abuse, adolescent pregnancy and violence in the media.

ALCOHOLISM SEMINAR—DePaul Rehabilitation Hospital is sponsoring a one-day seminar, "Alcoholism, Etiology, Diagnosis and Treatment," September 23 at the hospital's auditorium in Milwaukee, Wisconsin. Stanley Gitlow, MD., clinical professor of medicine, Mt. Sinai School of Medicine, New York, will be the keynote speaker.

The program meets criteria for CME Category 1 credits. For more information contact the DePaul Rehabilitation Hospital, Inc., 4143 S. 13th St., Milwaukee, WI 53221 or call (414) 281-4400.

LEUKEMIA RESEARCH SCHOLARSHIP—September 1 is the deadline to file applications for 1984 grants to research leukemia and related disorders. For application forms and more information write to the Research Grant Program, Leukemia Society of America, 800 Second Ave., New York, NY 10017.

AMA-ERF SCHOLARSHIPS—The American Medical Association-Education and Research Foundation is offering clinical nutrition scholarships to third and fourth year medical students who have completed the required clerkships in medicine, surgery and pediatrics.

Four to six week clerkships in general, pediatric and surgical nutrition are offered by 23 medical schools in the U.S. A copy of the AMA-ERF *Description of Clerkship Programs* for scholarships in clinical nutrition is available for student perusal in the dean's office of all U.S. medical schools.

Deadlines for application are: September 1 (for clerkships from December 1983 to June 1984) and February 1, 1984 (for clerkships from June to December 1984.)

ACC AWARD COMPETITION—Applications for the 1984 Young Investigators' Awards competition must be submitted to the American College of Cardiology (ACC) by September 9. Physicians and scientists in a residency program (or who have been in a residency program in the past three years), medical students and Ph.D. candidates are eligible to submit original manuscripts on any problem related to cardiology or circulation in biophysics, chemistry, radiology, surgery, basic science or clinical medicine. For more information contact ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814.

IDPH PHYSICIAN DIRECTORY UPDATE—The Division of Health Facilities Surveillance, Office of Health Regulation, Illinois Department of Public Health, is updating their directory of Illinois licensed physicians who are interested in providing services contractually. The Division often employs physicians who specialize in gerontology, psychiatry or general practice. If interested, please write: James A. Yuill, Chief, Division of Health Facilities Surveillance, Illinois Department of Public Health, 525 W. Jefferson St., 5th Floor, Springfield, IL 62761.

HEALTH ASSOCIATION RENAMED—The American Association of Foundations for Medical Care (AAFMC) has changed its name to the American Medical Care and Review Association (AMCRA).

ISMS MEDICARE SUPPLEMENT PLAN—ISMS members, age 65 and over, are now eligible for the ISMS Medicare Supplement Plan, underwritten by the Hartford Accident and Indemnity Company. This comprehensive plan covers charges for the annual Medicare deductibles, doctor's services, diagnostic Xrays, lab tests, anesthesia, drugs and many other hospital, medical and surgical services which are partially covered by Medicare. ISMS mailed brochures to all physicians in June. For more information, please call the ISMS insurance department.

INSURANCE FILM AVAILABLE—A new film on workers compensation is available from Wausau Insurance Companies. The 30-minute color film, titled "The Worker's Comp Connection," was produced in cooperation with the American Medical Association. The film focuses on the role physicians play in controlling costs and promoting injured employees' early return to work. For more information contact Wausau Insurance Companies, Communications Services, 2000 Westwood Dr., Wausau, WI 54401; (715) 842-6115.

SPINAL CORD SOCIETY CURE EFFORT—The Spinal Cord Society (SCS) is an international charitable research organization with 82 regional and overseas chapters. For further information on SCS or to obtain their monthly newsletter write to Michael Mercado, 5308 Colfax Ave., N. Hollywood, CA 91601.

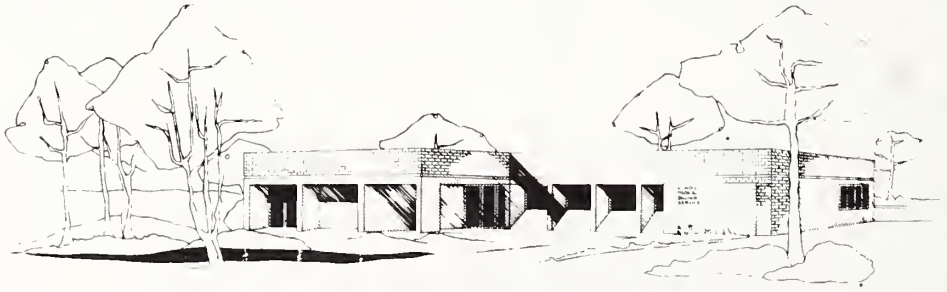
U OF C MEDICAL CENTER RECEIVES LAUREN KALIS FUND—Mr. and Mrs. Richard Kalis, the parents of Lauren Kalis, who died last winter of inoperable liver disease, have donated $300,000 to the University of Chicago Medical Center. The Lauren Kalis Fund was seeded by donations from thousands of Americans for Lauren's liver transplant. It will be used to develop a liver transplant program and to help pay for the pre-transplant evaluations of needy Chicago-area children suffering from liver disease and biliary atresia.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Family Practitioner. Excellent practice opportunity. Join young group of board-certified internists, family practitioners providing comprehensive health care in beautiful, wooded southern Illinois. Office adjacent to community hospital. Major state university (20 miles away), with medical school offers opportunity for affiliation. Administrative support provided. Guaranteed salary, bonus, fringes. Contact Susan Casey, Rural Health, Inc., 517 North Main Street, Anna, 62906 (618-833-4471). (8)

BREESE: Serving population 25,000. 40 miles east of St. Louis, near Carlyle Lake. Need OB-Gyn Physicians to share practice with present OB-Gyn Physician. Need Family Practice. Quality schools and colleges in area. Financial assistance available. CONTACT: Sr. Mary Anthony, St. Joseph's Hospital, Breese, 62230, (618) 526-4511. (11)

CAIRO: Seeking Emergency Medicine, Internist, and/or Family Practitioner to join multi-specialty medical group serving two-county area (pop. 20,000). Sixty miles south of Carbondale. Complete office facilities available with financial assistance. Outdoor recreation abundant. Contact: Steve Miller, Director, 529 Cross Street, Cairo 62914 (618-734-4200). (8)

FAMILY PHYSICIAN: University clinics, the Chicago Medical School. Board certified specialist in family medicine for full-time ambulatory clinical practice. Faculty appointment, medical administrative responsibilities, work closely with clinics administrator. Substantial benefits package, malpractice insurance paid. Send C.V. to: T.M. Robertson, Clinics Administrator, University Clinics, 3333 Green Bay Road, North Chicago, 60064, or telephone (312) 578-3244. (10)

MONMOUTH: Family practice physician needed immediately to assume well established practice in thriving Illinois agricultural community. 15 minutes from 91-bed JCAH accredited hospital with range of support services. Major university, private college and recreational facilities nearby. Submit C.V. to Victoria Hennenfent, Community Memorial Hospital, Monmouth, 61462 (309) 734-3141. (11)

Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

SEPTEMBER

Alcoholism

Alcoholism: Etiology, Diagnosis, Treatment
For: MD's. Course, Sept. 23, Milwaukee, WI. **Speaker:** Stanley Gitlow, MD. **Sponsor:** DePaul Rehabilitation Hospital, 4143 S. 13th St., Milwaukee, WI 53221. **Fee:** $100 (includes lunch). **Credit:** Category 1, 7 hours. **Contact:** Kathleen Alton. **Phone:** 414/281-4400.

Cardiology

Cardiology Board Review
For: Cardiologists, Internists. Course, Sept. 12-14, Knickerbocker Hotel, Chicago. **Speaker:** Leon Resnekov, MD. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** ACCP member, $350; non-member, $400. **Reg. limit:** none. **Credit:** Category 1, 34 hours. **Contact:** Dole Broddy. **Phone:** 312/698-2200.

Dermatology

Specialty Review in Dermatology
For: Dermotologists. Lecture, Sept. 26-30, Chicago. **Speaker:** Marshall Blonkenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390. **Reg. limit:** 90. **Credit:** Category 1, 34 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Hematology

Common Hemotologic Problems
For: GP's, FP's, Internists. Seminar, Sept. 24, Urbono. **Sponsor:** Corle Foundation Hospitol, 602 W. University Ave., Urbana 61801. **Reg. deadline:** 9/16. **Fee:** $35. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Deborah Rugg. **Phone:** 217/337-3022.

Immunology

Follow-Up in Immunology
For: MD's. Symposium, Sept. 7, 8:30 a.m., Waukegan. **Speaker** Allen Luskin, MD. **Sponsor:** Victory Memoriol Hospitol, 1324 N Sheridon Rd., Waukegon 60085. **Fee:** $10; $15, non-staff. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Maureen Bortholomew. **Phone:** 312/578-4006.

Internal Medicine

Specialty Review in Medical Oncology
For: Internists, Oncologists. Lecture, Sept. 19-23, Chicago. **Speaker:** John Merrill, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Internal Medicine

Specialty Review in Gastroenterology
For: Internists, Gastroenterologists. Lecture, Sept. 19-23, Chicago. **Speaker:** Ruven Leviton, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Internal Medicine

Specialty Review in Endocrinology & Metabolism
For: Internists, Endocrinologists. Lecture, Sept. 19-23, Chicago. **Speaker:** Sheldon Woldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathology

Specialty Review in Pathology: Anatomic
For: Pathologists. Lecture, Sept. 26-Oct. 1, Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Reg. limit:** 90. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview
For: Psychiotrists. Course, Sept. 30-Oct. 2, Chicago. **Sponsor:** The University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. **Fee:** $325. **Reg. limit:** none. **Credit:** Category 1, 20 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Spinal Cord Injury

Management of the Spinal Cord Injured Patient
For: MD's. Course, Sept. 12-14, Chicago. **Sponsor:** Rehabilitation Institute of Chicago/Northwestern University, 345 E. Superior St., Chicago 60611. **Reg. deadline:** 9/1. **Fee:** $200; $125, resident. **Reg. limit:** 110. **Credit:** Category 1, 17 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

Spinal Cord Injury

Frontiers in Spinal Cord Regeneration
For: MD's. Course, Sept. 15-16, Chicago. **Sponsor:** Rehabilitation Institute of Chicago/Northwestern University, 345 E. Superior St., Chicago 60611. **Reg. deadline:** 9/4. **Fee:** $250; $125, resident. **Reg. limit:** 110. **Credit:** Category 1, 14 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

Urology

Urological Pathology: Recent Developments and Current Concepts
For: Pathologists, Urologists. Workshop, Sept. 12-15, Chicago. **Sponsor:** American Society of Clinicol Pathologists, 2100 W. Harrison St., Chicago 60612. **Fee:** $500, members; $600, non-members. **Reg. limit:** 60. Credit: Category 1, 24 hours. **Contact:** Barb Agustin. **Phone:** 312/738-1336 X 188.

OCTOBER

Basic Science

Psycho-Pharmacology
For: MD's. Lecture, Oct. 19, 1:00 p.m., Sheraton Hotel, Naperville. Sponsor: DuPage County Medicol Society, 800 Roosevelt Rd., Bldg. 8, Glen Ellyn 60137. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours; AAFP Elective, 2 hours. **Contact:** Lillian Widmer. **Phone:** 312/858-9603.

Cardiology

Doppler and Two-Dimensional Echocordiography Workshop
For: MD's. Lectures/workshop, Oct. 17-20, Chicago. **Sponsor:** Northwestern University Medicol School/Northwestern Memoriol Hospitol, 250 E. Superior, Rm. 586, Chicago 60611. **Reg. deadline:** 10/3. **Fee:** $350. **Reg. limit:** 180. **Credit:** Category 1, 23 hours. **Contact:** Sharon Joseph. **Phone:** 312/649-4687.

Cardiology

Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmios
For: MD's. Conference, Oct. 6-8, Milwaukee, WI. **Sponsor:** U of Wisconsin—Extension, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 18 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Cardiopulmonary Medicine

Scientific Assembly
For: MD's. Conference, Oct. 23-27, Hyatt Regency Hotel/Illinois Center, Chicago. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30+. **Contact:** Dole Braddy. **Phone:** 312/698-2200.

Critical Care

Critical Care Medicine
For: Anesthesiologists, Internists, Pediotricians, Surgeons. Lecture, Oct. 24-28, Chicago. **Speaker:** Dharmopuri Vidyosagor, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Emergency Medicine

First Critical Hour
For: EMT, MD. Conference, Oct. 22, Normol. **Sponsor:** Illinois State University, College of Continuing Education, Normal 61761. **Reg. deadline:** 10/14. **Fee:** $30. **Reg. limit:** none. **Credit:** Category 1, 5 hours. **Contact:** Fronk Sponbouer. **Phone:** 309/438-8691.

Family Medicine

Therapeutics 1983
For: primory core physicions. Symposium, Oct. 29, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. Fee: $70. **Reg.** limit: none. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours; AOA, 6 hours. **Contact:** Sorah Aslokson. **Phone:** 608/263-2856.

Internal Medicine

Hepatic Diseases
For: MD's, Surgeons. Symposium, Oct. 11, 7:00 p.m., Vondalia. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Internal Medicine

Chest Pain Syndromes
For: Internists. Symposium, Oct. 20-22, Chicago. **Sponsor:** Center for Pain Studies, Rehabilitation Institute of Chicago; Northwestern University Medicol School, 345 E. Superior, Chicago 60611. **Fee:** $240; $150, residents. **Reg. limit:** 250. **Credit:** Category 1, 17 hours. **Contact:** Elly Henig. **Phone:** 312/649-6190.

Internal Medicine

Genetics of Diabetes and the Insulin Gene
For: MD's. Symposium, Oct. 5, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $50. **Reg. limit:** 150. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours; AOA, 6 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/367-9673.

Medicine

Medical Consequences of Nucleor Weopons/Wor
For: MD's. Lectures/workshops, Oct. 15, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed; AOA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Neurology

Contemporory Topics in Neurology
For: Neurologists, Psychiotrists, Neurosurgeons. Lecture, Oct. 17-21, Chicago. **Speakers:** Frank Rubino, MD; Sandra Olson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $420. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Ob/Gyn

Specialty Review in Obstetrics & Gynecology
For: Obstetricians, Gynecologists. Lecture, Oct. 17-22, Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Occupatianal Medicine

Medical Determinotions in Workers' Compensation
For: MD's. Symposium, Oct. 24-25, Chicago. **Sponsor:** American Society of Law & Medicine, 765 Commonwealth Ave., Boston, MA 02215. **Fee:** $200. **Reg. limit:** 300. **Credit:** Category 2, 12 hours. **Contact:** Barboro Schneider. **Phone:** 617/262-4990.

Pathalagy

Speciolty Review in Pothology: Clinical
For: Pathologists. Lecture, October 3-7, Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Psychiatry

Psychiotry Update
For: Surgeons, MD's. Symposium, Oct. 28, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Psychiatry

The Many Faces of Depression
For: MD's. Course, Oct. 21, Springfield. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Psychiatry

Contemporory Topics in Psychiatry
For: Psychiatrists. Lecture, Oct. 10-14, Chicago. **Speaker:** Francois Alouf, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $420. **Reg. limit:** 90. **Credit:** Category 1, 42 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Sparts Medicine

New Concepts in Wrestling Weight Management
For: GP's, FP's, Internists. Seminar, Oct. 28-29, Urbono. **Sponsor:** Carle Foundation Hospitol 602 W. University, Urbono 61801. Reg. deadline: Oct. 21. **Fee:** $35. **Credit:** Category 1, 5 hours; AAFP Elective, 5 hours. **Contact:** Deborah Rugg. **Phone:** 217/337-3022.

NOVEMBER

Cardialagy

Congestive Myocordiopathy
For: GP's, FP's. Seminar, Nov. 10, 2:00 p.m., Urbana. **Sponsor:** Carle Foundation Hospital, 602 West University Ave., Urbana 61801. **Reg. deadline.** 11/3. **Fee:** $35. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Deborah Rugg. **Phone:** 217/337-3022.

Cardialogy

Current Cordiology
For: Internists, FP's, GP's. Lecture, Nov. 28-Dec. 1, Chicago. **Speaker:** Stuart Rich, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $310. **Reg. limit:** 90. **Credit:** Category 1, 22 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Chemical Dependence

Office & Hospital Treotment of Chemical Dependence
For: Psychiatrists, Internists, GP's, FP's. Lecture, Nov. 7-9, Chicago. **Speaker:** Francois Alouf, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: $280. **Reg. limit:** 55. **Credit:** Category 1, 20 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Internal Medicine

Advances in Internol Medicine
For: Internists. Lecture, Nov. 14-18, Chicago. **Speaker:** Sheldon Woldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390. **Reg. limit:** 90. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Medicine

Antibiotic Usoge
For: Surgeons, FP's. Symposium, Nov. 8, 7:00 p.m., Effinghom. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Pain

Management of Poin
For: MD's. Symposium, Nov. 3, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Pain

Pain Conference
For: MD's. Symposium, Nov. 18-19, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed; AOA. **Contact:** Sarah Aslokson. **Phone:** 608/263-2856.

Pathalagy

Urologic Pothology & Rodiology
For: Urologists, Pothologists, Radiologists. Lecture, Nov. 28-Dec. 2, Chicago. **Speaker:** Thomos John, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 55. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathology

Visiting Clinician in Surgicol Pathology
For: Pathologists. Course, one or two weeks (year-round), Chicago. **Sponsor:** The University of Chicago, 950 E. 59th St., Box 139, Chicogo 60637. Fee: $440/wk. **Credit:** Category 1, 40 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Pathalagy

Surgicol Pathology of the Lung ond Reloted Lesions of the Mediostinum
For. Pothologists. Course, Nov. 14-17, Chicogo. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison St., Chicogo 60612. **Fee:** $500, members; $600, non-members. **Reg. limit:** 60. **Credit:** Category 1, 24 hours. **Contact:** Barb Agustin. **Phone:** 312/738-1336 × 188.

Plastic Surgery

Monagement of Upper Extremity Injuries
For: MD's. Symposium, Nov. 12, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. limit:** 150. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours. **Contact:** Loretta Giocoletto. **Phone:** 314/367-9673.

Respirotary

Respiratory Critical Care Symposium
For: MD's. Symposium, Nov. 3-4, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $210; $125, resident. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed; AOA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Surgery

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, Nov. 14-16, Chicogo. **Speoker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Flexible Fiberoptic Sigmoidoscopy
For: Abdominol Surgeons, Internists, Gastroenterologists. Lecture, Nov. 19, Chicogo. **Speoker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $125. **Reg. limit:** 60. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

RECENT CME ACCREDITATIONS

The ISMS Committee on Accreditation has approved the CME programs of the following institutions:

Central DuPage Hospital, Winfield
Elgin Mental Health Center
Glendale Heights Community Hospital
Henry Horner Children's Center, Chicago
Hinsdale Sanitarium and Hospital
Loretto Hospital, Chicago
MacNeal Memorial Hospital, Berwyn
Mercy Hospital and Medical Center, Chicago
Riveredge Hospital, Forest Park
Rockford Memorial Hospital
Sherman Hospital, Elgin
St. Elizabeth's Hospital, Chicago
St. Mary's Hospital, Streator

Eleventh Annual Congress/CME

CME Goals, Objectives and Evaluation

The Critical Link

October 14-15, 1983, at the Drake Oakbrook Hotel

West 22nd Street at York Road, Oak Brook, Illinois

The major emphasis of the 1983 Congress is to provide direction in the development and implementation of appropriate goals, objectives and evaluation techniques in offering effective CME programs to respond to physicians' learning needs.

The Congress will take place from Friday morning, October 14 to Saturday afternoon, October 15. You are offered a wide variety of small group workshops, as well as the opportunity for individual consultations with CME experts. These are arranged to assist CME planners who attend the Congress with specific planning problems.

"What is the Future of CME?" is the topic of debate to be presented by the distinguished keynote speakers: Gerald Escovitz, M.D., vice dean, The Medical College of Pennsylvania; Jacob Suker, M.D., associate dean of graduate education, Northwestern University Medical School and William Ruhe, M.D., former vice president, scientific activities, American Medical Association. The future of CME will be addressed from three separate perspectives, including CME sponsors, accreditation and organized medicine.

The small group workshops this year will include such topics as computer assisted instruction and the application of microcomputers to CME, problem based learning modules and the opportunities and limitations of evaluation in CME. Other topics include methods of delivering CME from lectures to advanced communications and use of malpractice data in developing goals and objectives.

Three additional workshops are specifically designed for the non-physician medical educator and administrative support staff.

For additional information, write or call the Illinois Council/CME, 55 East Monroe, Suite 3510, Chicago, Illinois 60603, (312) 236-6110. ◂

Classified Advertising

All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of $2 will be assessed when a box number is requested.

CLASSIFIED ADVERTISING RATES

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	$6.00	$9.00	$14.00	$20.00
3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

POSITIONS AND PRACTICE

FAMILY PRACTITIONER/INTERNAL MEDICINE—To locate in Rosiclare, Illinois. 49-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forrest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare, IL. 62982. (618) 285-6634.

EMERGENCY MEDICINE: PART-TIME AND FULL-TIME positions available in over 20 emergency departments located in central and southern Illinois. Earn a competitive income while enjoying the many challenges emergency medicine offers. Flexible scheduling and paid professional liability insurance provided. For complete details write or call Catherine Offut, Spectrum Emergency Care, Inc., 999 Executive Parkway, P.O. Box 27352, St. Louis, MO 63141; 1-800-325-3982.

EXCELLENT OPPORTUNITY in Northwest suburbs for child psychiatrist working part time or full time in private group practice involving inpatient and outpatient adolescent, child and adult care. Must have inpatient adolescent experience and board eligibility. Please send vitae to Box #1076 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

ASSISTANT DIRECTOR—4 y/o approved community based family practice residency affiliated with Southern Illinois University. Generous salary and fringes for M.D. (board certification highly desirable). Assistant professor or higher rank depending upon background. Administration, teaching and practice responsibilities. Applications accepted until position filled. Reply to: David Ouchterlony, M.D., Director, Decatur Family Practice Center, 1314 N. Main, Suite 201, Decatur, IL 62526 (217) 423-8186. S.I.U. School of Medicine is an Equal Opportunity/Affirmative Action Employer.

FAMILY PRACTITIONER, OBSTETRICIAN-GYNECOLOGIST, GENERAL INTERNIST needed to staff Carle Clinic—Danville Satellite. Satellite physicians are part of a large multi-specialty clinic group which provides financial, administrative, educational and medical specialty support. Liberal fringe benefits include adequate time off for educational meetings and vacation. University teaching opportunities available. Write including CV to John W. Pollard, M.D., Executive Vice-Chairman, Carle Clinic, Urbana, Illinois 61801.

FAMILY PRACTITIONER—Exceptional opportunity to take over profitable practice in central Illinois community near Springfield: will remain to introduce. Fully-accredited 60-bed hospital in town. Write Box 1082, c/o Illinois Medical Journal, 55 East Monroe, Suite 3510, Chicago, Illinois 60603.

ANESTHESIOLOGIST retired, looking for part-time or locum tenens for anesthesia coverage anywhere in Illinois; anytime. Call (312) 361-1848.

CARDIOLOGIST: Partnership opportunity in community located on Lake Michigan between Chicago and Milwaukee. Noninvasive and clinical emphasis. Excellent medical facilities. Guaranteed salary, complete benefits. Senior partner retiring. Contact Phillip Kelbe, Fox Hill Associates, 260 Regency Court, Waukesha, WI 53186, (414) 785-6500 (no fees).

TWO RESIDENCY-TRAINED FAMILY PHYSICIANS needed to expand established family practice in Tomah, Wisconsin (population 7,000). Current physician (ABFP) wants to reduce high volume and incorporate more elements of contemporary family medicine. Attributes include: good professional support, attractive and equitable compensation, good prospects for further recruitment, viable 79-bed local hospital, growing community, tremendous recreational resources and formal association with 50-physician multispecialty group. Practice family medicine the way you've been trained and without constraints from other specialists. Contact: P.S. Shultz, MD., Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S. 10th St., La Crosse, WI 54601. Phone (608) 782-9760.

CHICAGO: EXPERIENCED GENERAL PRACTITIONER wanted for Urgent Care Clinics in new southwest suburban Chicago areas. Regular hours, no night call. Minimum guarantee with capitation or fee-for-service. Call or send CV to Dr. Wadley at P.O. Box 356, Winnetka, IL 60093, (312) 441-7162.

CARDIOLOGISTS—To join well-established cardiovascular referral practice in Pennsylvania. Abilities in management of hospital patients, full invasive and noninvasive diagnostic testing required. Excellent beginning salary and fringe benefits. Opportunity to become full member of corporation at 18-24 months. Respond with CV to P.O. Box 1086 c/o the Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

GENERAL PRACTICE FOR SALE—Excellent western suburban location. Close to two community hospitals. Well equipped, two exam rooms and a consultation room. Located next door to pharmacy. Call (312) 231-1121.

LARGE GENERAL PRACTICE interested in taking on an associate. Liberal terms—flexible. If interested send resume or letter to: John D. Kelly, M.D., 13 South Second St., Geneva, IL 60134.

FAMILY PHYSICIANS—Unique opportunity for BC/BE family practice physician to join prepaid group practice in Kansas City. To staff and develop a family practice facility 15 minutes from established multi-specialty group practice. Facility will include laboratory, X-ray and pharmacy. Attractive salary structure and liberal fringes. Starting salary based on experience. Recruitment and relocation expenses covered. Send CV to Michael R. Soper, M.D., 6801 E. 117th St. Kansas City, MO 64134, or call (816)765-6200.

WANTED—ILLINOIS LICENSED PHYSICIANS to perform insurance physicals. Also ECG. Full or part time on a mobile basis. Please call (312) 763-8744.

INVASIVE CARDIOLOGIST—Hospital rounds duties and some diagnostic testing. Mid-Atlantic states area. Abilities to do streptokinase and/or angioplasty desirable. Salary and bonus. Respond with CV to Box #1087 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

OBSTETRICIAN/GYNECOLOGIST: To join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 S. Kiwanis Dr., Freeport, IL 61032.

GENERAL PRACTICE FREE with purchase of home office. Ideal location in rural southern Illinois for family practice. Town recently without doctor with drawing population of 6000. Five hospitals and medical school within 20 min. Home has seven rooms, pool, tennis court and four acres. Physician retired due to health. $90,000. Financing available with minimal down payment. Call (813) 493-5929.

U.S. AIR FORCE MEDICAL CORPS currently is accepting applications for physicians in the following specialties: surgery (all specialties), obstetrics/gynecology, otorhinolaryngology, anesthesiology, and urology. For further information call collect, Captain Brian Legg, (312) 263-1207.

MEDICAL DIRECTOR (Psychiatrist) CHAMPAIGN—Community Mental Health Center offers comprehensive services to all age groups. Staff of two consulting psychiatrists and 35 experienced doctoral and masters level counselors. Present director leaves in October. Thirty-five hours per week plus on-call responsibility. Private inpatient work with center patients required for continuity of care. Income guaranteed to $68,000 plus liberal fringes. Potential income to $110,000. Affiliation with medical school and university hospital are possible. Illinois license, board certification, willingness to work with team delivery. Contact: Gregory J. Sikora, Executive Director, 600 E. Park Ave., Champaign, IL 61820 (217) 398-8080. EOE.

OB/GYN SPECIALIST—Enjoy the security of group practice with the freedom of independent practice. If you are board certified or board eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, P.O. Box 1646 Wausau, WI 54401.

ASSOCIATE OPHTHALMOLOGIST desired, part time, Elgin area. One day per week. Write to Box #1089 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

GROWING NORTHSIDE CHICAGO HOSPITAL seeking specialists in general surgery, orthopedics, internal medicine and family practice. Looking for practicing physicians who desire challenging practice opportunities with medium size hospital. Please send serious inquiries to Box #1091 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

GROWING NORTHSIDE CHICAGO HOSPITAL seeking American trained board certified or board eligible internal medicine physician for house staff position, starting January 1, 1984. Attractive compensation package and practice opportunities available. Please send inquiries to Box #1092 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimum practice setting in our Sun City, AZ healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, P.O. Box 29030, Phoenix, AZ 85038 (602) 954-3506.

PHOENIX, AZ. PRACTICE FOR SALE Retiring after 37 years at location near all major hospitals. Practice—$20,000; $5000 down, $400 monthly. $600 office rent includes utilities, taxes. Property (if desired)—$100,000, has two rentals ($250 and $185). Phone (602) 253-3092.

CARDIOLOGIST: Board eligible or certified to serve as Medical Director of Cardiology Service. Responsibility includes developing diagnostic and rehabilitative program as well as establish private practice. Community of 22,000 with 248 bed fully equipped hospital with 37 physicians on staff. Service population of 70,000. Practice guarantees provided, and other assistance from hospital. Located 60 miles from Joliet and Peoria near Illinois River. Please call Phil Kelbe at 414/785/6500 collect for further information.

PHYSICIAN RETIRING after 45 years of general practice in unusually desirable location. Twenty minutes from St. Louis, MO. Growing town of 5,000, collections excellent. Modern office. Great opening for family practice or internal medicine. Write to Box #1094 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

SUCCESSFUL FAMILY PRACTICE for sale in attractive Rockford (population 140,000); 80 miles from Chicago. Ideal location two minutes from hospital. Call (815) 397-8316.

GROW WITH US—Excellent practice opportunities for family practitioners, pediatricians, obstetricians, internists, and general surgeons, either with an established medical group or independently. Modern 100 bed acute care hospital with new ICU and 24 hour emergency department, serving a population of approximately 40,000 people. The hospital is proposing to build a physician's office complex on its campus. Financial assistance available includes: guaranteed first year income, subsidies for office space and personnel and other benefits. Send CV or contact: Thomas E. Cecconi, Administrator, Paris Community Hospital, Post Office Box 299, Paris, Illinois 61944, 217/465-4141.

CHIEF MEDICAL OFFICER for Department of Corrections in Missouri. Administrative work combined with medical duties. Stable employment in a middle class city. Immediate opening. Contact: Melvin Gardiner, Personnel Officer, PO Box 236, Jefferson City, MO 65102.

PHYSICIAN NEEDED TO SERVE AS MEDICAL COORDINATOR of progressive north-shore hospital. Newly-created position includes broad range of responsibilities in both medical and surgical fields. Ideal candidate will have background in family practice or internal medicine. Hours are 11 a.m. to 7 p.m., Monday through Friday. Generous fringe benefit package. Contact Sushil K. Sharma, M.D., director of intensive care, Skokie Valley Hospital, 9600 Gross Point Road, Skokie, IL, 60076. Tel: (312) 677-9600, ext. 533.

ASSISTANT DIRECTOR—5 y/o approved community based family practice residency affiliated with Southern Illinois University. Generous salary and fringes for M.D. (board certification highly desirable). Assistant professor rank with administration, teaching and practice responsibilities. Applications accepted until position filled. Reply to: Albert Ripani, Jr., M.D., Director, Decatur Family Practice Center, 1314 N. Main, Suite 201, Decatur, IL 62526 (217) 423-8186. S.I.U. School of Medicine is an Equal Opportunity/Affirmative Action Employer.

POSITION OPEN: MEDICAL OPHTHALMOLOGIST wanted in large midwest practice that is affiliated with university training program. Excellent medical skills required. Knowledge of Argon Laser preferable. Opportunity to assist in surgery and learn yag laser available. Salary $75,000.00 plus generous benefits and rapid advancement depending on qualifications. Send resume to: Box 1095 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

SITUATIONS WANTED

BELLEVILLE OR NEAR VACINITY. Well established, active general/family practice. Wanted immediately. Reply to Box #1075 c/o Illinois Medical Journal, 55 Monroe St., Suite 3510, Chicago, IL 60603.

POSITION WANTED—May 1983 graduate physician assistant program, U.W. Madison. Desire position north suburban Chicago area in HMO, family practice, internal medicine, obstetrics-gynecology or pediatrics. Preceptorship experience in history-taking and physical examination; monitoring in-hospital therapy and writing progress notes; patient evaluation in office setting; emergency room; surgical assisting. Twelve years previous experience as registered medical technologist. Relate well to patients and enjoy patient contact. Write Jean Hamilton, 1928 Harrison, Evanston, IL 60201.

MATURE PHYSICIAN with strong internal medicine and pulmonary background seeks primary care practice in rural midwest. Write to Box #1085 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

LICENSED PHYSICIAN ASSISTANT, trained in Europe and U.S., versatile in medicine, is seeking position with hospital, physician, clinic etc. Write to Box #1090 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

VASCULAR/GENERAL SURGEON: 34, board certified, university trained, recently completed peripheral vascular fellowship. Seeks partnership or group. Write to Box 1093 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

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DOCTOR RETIRING. FULLY EQUIPPED MEDICAL CLINIC, established general practice 25 years + real estate. Perfect for young Spanish-speaking doctor. Near Ashland and North Avenue in Chicago. Only $15,000 down payment. Owner finances balance $64,900 at 10%. Monthly payments—P&I—$626.30. Income from four apartments—$650 monthly. Fox Realtors (34) (312) 769-2500.

FURNISHED OFFICE SPACE FOR RENT by day or month. Excellent location near Old Orchard Shopping Center, Skokie, Illinois. Good offices for psychiatrist, psychologist, social workers. Ample parking. Reply to Box #1088 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

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FOR SALE: OFFICE HOME combination in Wyoming, Illinois, 25 miles north of Peoria. After many years of practice, physician retiring. Please phone (309) 695-3711. Write Box 100, Wyoming, IL 61491.

OLD ORCHARD BUILDING—675 Square feet, excellent location. 6 rooms includes 2 exam rooms, reception area, business/file room, small lab, consultation room. Available immediately. Call (312) 674-4052/(312) 677-9859.

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MISCELLANEOUS

RECEIVABLES. There are advantages to having an attorney handle your past due accounts. To discuss these advantages and your receivable problems call M. Turek, attorney specializing in creditor's rights, (312) 951-8515.

ANTERIOR SEGMENT FELLOWSHIP in busy private practice associated with Medical College. Intraocular Lens Implantation, including posterior chamber and anterior chamber lenses. Extracapsular and Phacoemulsification techniques. $40,000 plus fringes. Send CV and career objectives to Box #1077 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

VACATION ON BEAUTIFUL KENTUCKY LAKE. New fleet luxury houseboats, rentals. Sleep 8-10. All lake front cottages, camping sites, full service marina. Restaurant, weekend buffets April to Labor Day. Guide service, boat rentals, beach. The Moors Resort & Marina, Rt. 2, Gilbertsville, KY 42044. (502) 362-4356. Reserve early!

HOW TO KEEP KIDS HAPPY—PLAYSCAPE (TM) centers. Rugged, compact, colorful, two-level children's activity structure for your waiting room. A marketing idea already proven by over 60,000 happy little Wisconsin patients. Educational, imagination-stretcher play stations. Irresistible crawl spaces. No loose toy clutter . . . just lots of fun. Your pediatric patients relax and come to your examining room in a cooperative frame of mind. Space savers. Staff pleasers. European "knock-down" connectors make assembly simple with no schedule interruptions. Call or write for a free color brochure today. Playscapes, Children's Environments, 902 Spaight St., Madison, WI 53703. (608) 251-0238.

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INTERESTED IN FINDING A CERTIFIED PHYSICIAN ASSISTANT for your busy practice? A free placement service is offered through: Illinois Academy of Physician Assistants, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

ESTABLISHED PROFESSIONAL CHICAGO chamber music ensemble is seeking one or two additional persons to be dedicated pro bono members of Board of Directors. Please contact Jeffrey Gettleman, (312) 856-2257.

LOOKING FOR A PROFESSIONAL OPPORTUNITY that offers you a rewarding practice plus a good lifestyle? Try us. We'd like to help you make your best match in one of our more than 75 communities throughout the Midwest and Mountain states. These practices offer challenge and growth. The locations offer the best possible lifestyle in a good environment where you can spend time with your family. Contact: Mary Helen Pelton, Ph.D. (701)777-3848, The Office of Rural Health, University of North Dakota School of Medicine, Grand Forks, ND 58201. We make the intelligent match.

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86	**Illinois State Medical Inter-Insurance Exchange**
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104	**Eagle Lands**
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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

September 6	Little Company of Mary Hospital & Chicago Lung Assn.	Evergreen Park
September 12	Mercy Hosp. & ACS	Urbana
September 13	Illinois Interagency Council on Smoking & Disease	Chicago
September 13	Indian Trails Library & ACS	Wheeling
September 19	Lutheran General Hosp. & Chicago Lung Assn.	Park Ridge
September 22	American Cancer Society Training	Chicago
October 3	ANCHOR	Chicago
October 3	Condell Memorial Hospital & ACS	Libertyville
October 3	Lake Forest Hospital & ACS	Lake Forest
October 4	St. Francis Hospital & ACS	Blue Island
October 11	Illinois Interagency Council on Smoking & Disease	Chicago
October 12	St. Therese Area Trauma Satellite & ACS	Lake Villa
October 17	Lutheran General Hosp. & Chicago Lung Assn.	Park Ridge
October 20	American Cancer Society	Chicago
October 23	Victory Memorial Hospital	Waukegan
November 1	Illinois Interagency Council on Smoking & Disease	Chicago
November 7	Lutheran General Hosp. & Chicago Lung Assn.	Park Ridge
December 5	ANCHOR	Chicago
December 6	Illinois Interagency Council on Smoking & Disease	Chicago
January 3, 1984	Illinois Interagency Council on Smoking & Disease	Chicago
February 1	Illinois Interagency Council on Smoking & Disease	Chicago
March 6	Illinois Interagency Council on Smoking & Disease	Chicago
April 3	Illinois Interagency Council on Smoking & Disease	Chicago
May 1	Illinois Interagency Council on Smoking & Disease	Chicago
June 5	Illinois Interagency Council on Smoking & Disease	Chicago

President's Page

DRGs: Diagnosis Related Groups



Following the advent of Medicare in 1964, the medical profession experienced a continual posturing about the potential legislative climate for the passage of other social legislation which, in the opinion of many of us, would have led to national health insurance in the United States. For a multiple of political, social and economic reasons none of these came to pass and it wasn't until the Spring of 1983 that significant health legislation affecting all of the insureds under Medicare came into being.

On April 20, President Reagan signed the Social Security Act Amendments of 1983 (PL 98-21) providing that hospitals would be reimbursed for services provided to Medicare beneficiaries via a *prospective* payment system. This major cost containment initiative by the Congress and the President limited federal payment to hospitals to a fixed price per discharge based on the Medicare patient's discharge diagnosis, using a classification known as Diagnosis Related Grouping (DRG) developed by Yale University researchers.

The implementation of this method of prospective payment is to begin on October 1, 1983 and cover a span of three years. The phase-in is designed to allow time to work out the hospital's need to shift from a reimbursement system of payment for "reimbursable costs" to one of prospective payment.

During late July, the Illinois State Medical Society sponsored three educational seminars on Diagnosis Related Groups. We were pleased at the response to our program, as 1,100 physicians attended. This educational effort should continue at the county, specialty society and hospital medical staff levels and will be a key part of our symposium in November.

Briefly, the Diagnosis Related Group is determined by the hospital from the discharge diagnosis and data recorded in the medical record by the attending physician. Overall, there are 467 such DRGs—but only 356 apply to the Medicare patient and will be used in this prospective payment system.

The hospital will be paid a fixed amount for each DRG as stated above, placing some new nuances between the physician and the hospital. The physician will notice more pressure to keep timely, accurate and complete medical records and to ensure the documentation of co-morbidity and complications in these data.

Jeff Goldsmith, Ph.D., during the above mentioned DRG conference, suggested that Congress and the Administration delegate the responsibility for this method of cost containment to the hospitals rather than grapple with the physicians in another arena. If this is so, then it is plausible that the hospital will delegate to the medical staff and the physicians of the community the responsibility for assuring that the system is using the most appropriate DRG designation.

It does not stop there. Congress also has decided to study the implications of an all-payer DRG reimbursement system. A report of this study is expected to be completed and returned to Congress

during late 1984 and early 1985. Furthermore, the implementation of a physician payment system based on a DRG principle for their inpatient care of Medicare recipients is scheduled for a report from HCFA in early 1984.

Underlying the above is the enigma that, during three years of usage, New Jersey has not been able to present positive statistical data showing that its DRG system has significantly affected the cost of medical care in that state.

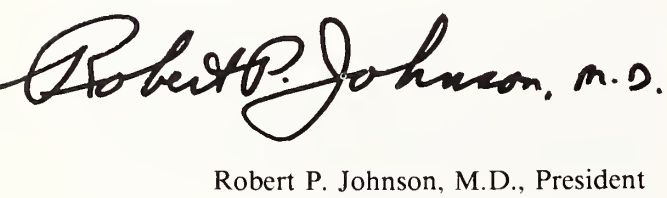
Last but not least is the subject of the Peer Review Organization (PRO) which will be the subject of my next President's Page. PRO impacts on the DRG prospective payment system because each hospital must have a contract with a PRO to receive payment for the services delivered to Medicare patients under the DRG principle.

The peer review demands of this federal action include the following, (I quote from the AMA Council on Medical Service Report F presented at the Annual Meeting of 1983): (a) the validity of diagnostic information provided by the hospitals for purposes of DRG-based payment; (b) the completeness and adequacy of care; (c) the appropriateness of admissions and (d) the appropriateness of care provided to "outlier" cases (those cases involving prolonged stay or unusual utilization).

As you can see, this is a new demand on physicians which I believe should be based on local determination of how this is to be carried out in any medical service area.

Earlier this summer, each ISMS member received a brochure titled "What Physicians Should Know About DRGs." I recommend that this be given a high priority place on your reading table. The office of your state medical society still has a limited number of these available in case you have misplaced the one mailed to you or have other friends and leaders in your community with whom you wish to share this information. You might even consider sharing this with Medicare patients as a matter of their education.

More on alphabetized medical care next month. ◀



Robert P. Johnson, M.D., President

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nitedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Pfizer LABORATORIES DIVISION
PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Obituaries

***Allison, Chas,** Kankakee, died May 8, 1983 at the age of 77. Dr. Allison was a 1934 graduate of the University of Cincinnati College of Medicine.

***Cejtin, Michael,** Waukegan, died June 24, 1983 at the age of 67. Dr. Cejtin was a 1950 graduate of the *Facolta di Medicina e Chirurgia dell'University di Torino,* Italy.

***Ditkowsky, Sol Paul,** Lincolnwood, died July 26, 1983 at the age of 71. Dr. Ditkowsky was a 1938 graduate of Northwestern University Medical School, Chicago.

****Ellis, Bernard Edgar,** Tampa, Florida, died February 20, 1983 at the age of 88. Dr. Ellis was a 1924 graduate of the St. Louis University School of Medicine.

****Kelikian, Hampar,** Chicago, died July 24, 1983 at the age of 84. Dr. Kelikian was a 1928 graduate of Rush Medical College, Chicago.

***Krol, Edward,** Evergreen Park, died July 4, 1983 at the age of 70. Dr. Krol was a 1940 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Lerner, Harry Barney,** Laguna Niguel, California, died June 19, 1983 at the age of 62. Dr. Lerner was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

***Levin, Sheldon I.,** Chicago, died July 21, 1983 at the age of 63. Dr. Levin was a 1945 graduate of the University of Health Sciences, Chicago Medical School.

Rider, Jeanette L., Riverside, died June 27, 1983 at the age of 84. Dr. Rider was a 1927 graduate of Rush Medical College, Chicago.

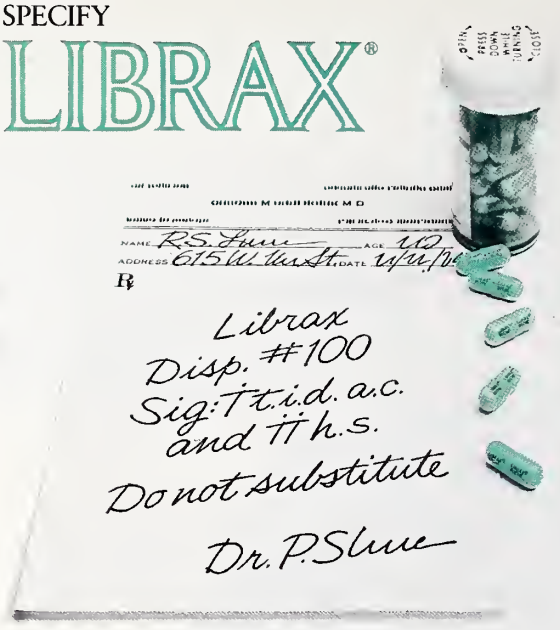
****Urnes, Magnus P.,** Chicago, died June 24, 1983 at the age of 88. Dr. Urnes was a 1922 graduate of Northwestern University Medical School, Chicago.

***Weiss, Leon H.,** Chicago, died July 25, 1983 at the age of 67. Dr. Weiss was a 1941 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Weiss, Samuel J.,** Ojai, California, died January 2, 1983 at the age of 89. Dr. Weiss was a 1919 graduate of the Hahnemann Medical College and Hospital, Chicago

**Indicates ISMS member.*
***Indicates member of Fifty Year Club.*

SPECIFY
LIBRAX®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

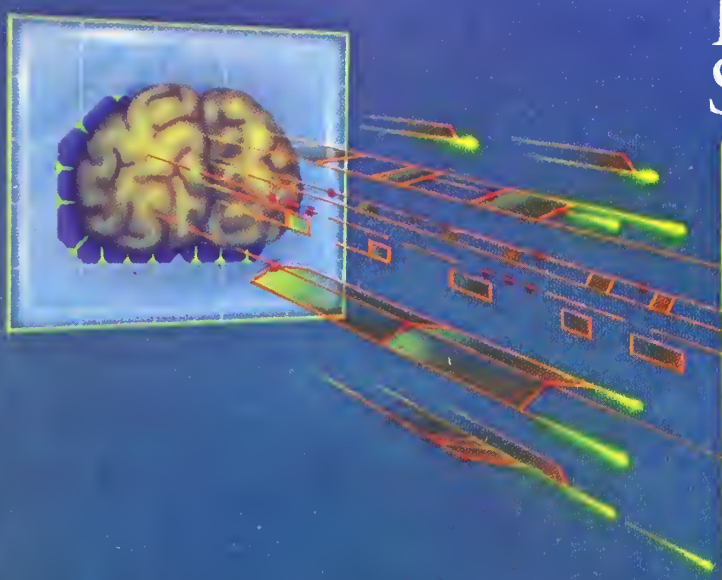
*

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCE®
Roche Products Inc.
Manati, Puerto Rico 00701

PATHWAYS TO IRRITABLE BOWEL SYNDROME*





Illustrated here is the connection between emotional anxiety and the altered state of intestinal motility of irritable bowel syndrome.[1-3] While no abnormalities may be seen after physical examination or blood tests on these patients,[2] the slow rhythms of their intestines have been found to be more prominent than normal when they are symptomatic *and* when they are symptom-free.[3]

PATHWAYS TO TREATMENT
...OF THE EMOTIONAL AND PHYSICAL FACTORS

THE ANTIANXIETY ACTION OF LIBRIUM® (chlordiazepoxide HCl/Roche)

The presence of Librium in the Librax combination serves as a calming agent for the patient with irritable bowel syndrome. Librium has an unequaled record of efficacy and safety and seldom impairs mental acuity. Patients should be cautioned, however, about taking any CNS-acting agent while performing activities that are hazardous or require complete mental alertness.

THE ANTISPASMODIC/ ANTISECRETORY ACTIONS OF QUARZAN® (clidinium bromide/Roche)

The Quarzan in Librax provides anticholinergic action that can aid in the control of hypersecretion and irregular intestinal motility to relieve the distressing abdominal symptoms of irritable bowel syndrome.

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of irritable bowel syndrome.
Please see brief summary of prescribing information on preceding page.

References: 1. Sandler RS, Drossman DA: *Intern Med 2*(1):39-47, Jan 1981. 2. Mendeloff AI: *Practical Gastroenterol 3*(3):12-18, May-Jun 1979. 3. Connell AM: *The Female Patient 5*(9):20-22, Sep 1980.

SPECIFY ADJUNCTIVE

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

ANTIANXIETY
ANTISECRETORY
ANTISPASMODIC

ROCHE®

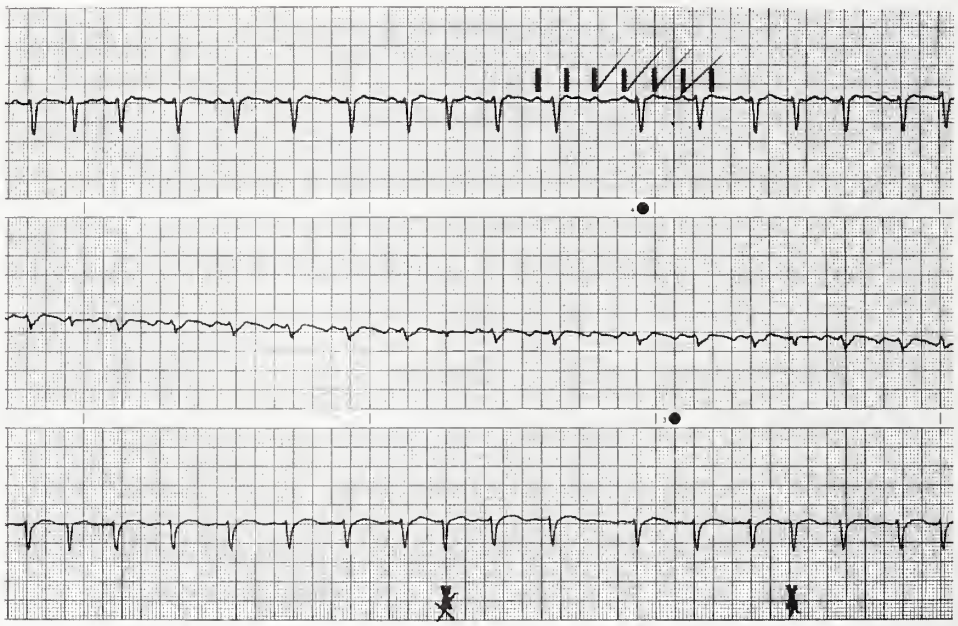
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EKG of the Month

CONTRIBUTING EDITORS: JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D., PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D., JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This patient is a fifty-three year old man whose history of cardiac illness had begun two years earlier. At that time he sustained an acute anterolateral myocardial infarction and a cardiac arrest. He was successfully resuscitated and later developed angina. Cardiac catheterization and coronary angiography demonstrated a large anterolateral and apical left ventricular aneurysm with coronary artery disease. Aorta coronary saphenous vein bypass surgery and a left ventricular aneurysmectomy were performed.

In the postoperative period, frequent premature atrial and ventricular beats with intermittent atrial fibrillation were seen and treated. He presented to the emergency service with palpitations and dyspnea. These symptoms had awakened him from sleep and lasted only an hour at first. Two hours later they returned, now associated with a chest soreness in addition to dyspnea. Physical examination showed a pulse rate of 100 beats per minute and a blood pressure of 110/80mmHg. His neck veins were distended to the angle of the jaw. The lungs contained basilar brhonchi and a ventricular gallop was heard. His medications included digoxin, quinidine, and potassium chloride. This simultaneous lead V_1, II, and V_5 rhythm strip was obtained.



Questions:

1. **The simultaneous leads V_1, II and V_5 rhythm strip shows:**
   - A. Atrial tachycardia with 2:1 atrioventricular block
   - B. Left axis deviation and probable left anterior hemiblock.
   - C. Atrial flutter with 2:1 atrioventricular block.
   - D. An accelerated junctional rhythm with atrioventricular dissociation.
   - E. Premature atrial beats.

2. **The following statement(s) is/are true.**
   - A. This arrhythmia is commonly associated with digitalis toxicity.
   - B. Carotid sinus massage usually converts this arrhythmia to normal sinus rhythm.
   - C. The patient's symptoms are often determined by the patient's underlying heart disease.
   - D. There is evidence that this arrhythmia can be caused by a re-entry or ectopic mechanism.
   - E. This arrhythmia is commonly regular but can become irregular with treatment.

(Continued on page 164)

Tranxene® extends a helping hand to the anxious patient



Acts rapidly with little likelihood of drug-induced amnesia.

Calms effectively with low incidence of problem sedation.

Tapers smoothly when therapy ends, without likelihood of rebound insomnia.

Tranxene studies have not specifically investigated amnesia or rebound insomnia —but the record is impressive. In over a decade of widespread Tranxene experience there have been no reports in the medical literature linking Tranxene to any of these problems.

And in direct comparison studies, Tranxene has proved equal to or lower than diazepam in problem sedation (i.e., moderate to severe sedation, sleepiness, drowsiness, lassitude).

TRUST TRANXENE®

(clorazepate dipotassium Ⓒ IV)

3.75, 7.5, and 15 mg capsules

Please see brief summary on an adjacent page.

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant.

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

TRUST TRANXENE®
(clorazepate dipotassium ©)
3.75, 7.5, and 15 mg capsules

Abbott Pharmaceuticals, Inc.
North Chicago, IL 60064

3063458

EKG

(Continued from page 162)

Answers: 1. B, C 2. C, D, E

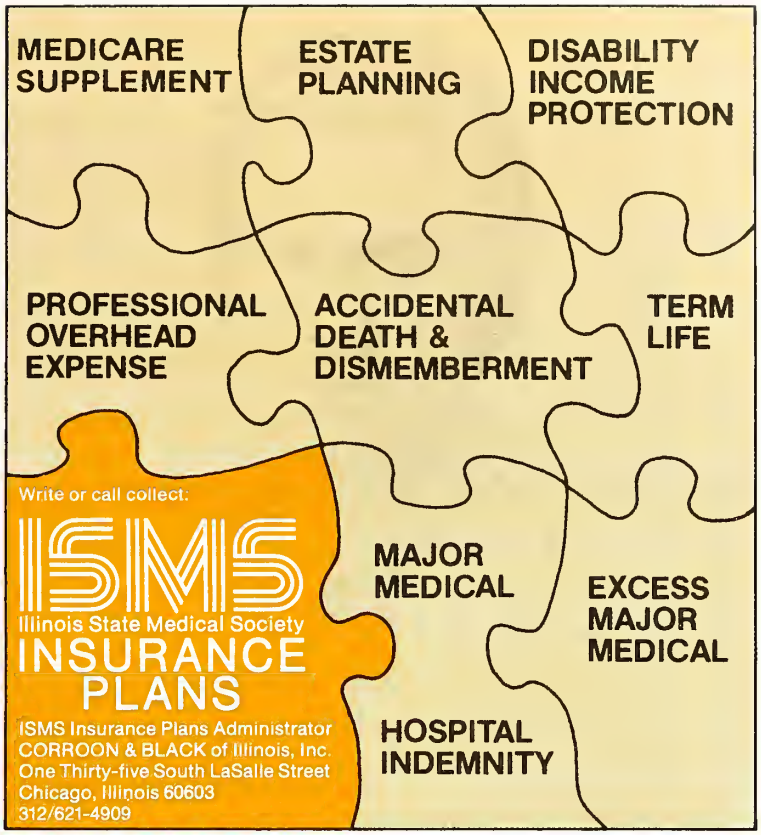
Although this arrhythmia almost looks like a sinus or atrial tachycardia to the left of the ECG strip, a break in the R-R cycles reveals many P waves. The black bars are over each P wave and show an atrial rate of 200 beats per minute. This is 2:1 atrioventricular block. Digitalis intoxication was considered in this patient because a digitalis-quinidine interaction was suspected. Many studies have shown that quinidine can elevate the serum digoxin level. The serum digoxin level was only 0.6mg and the quinidine level was 2.6mg. Actually, the digoxin level was low. This is really atrial flutter with 2:1 atrioventricular block, occasionally conducting in a 3:2 Wenckebach sequence (see the X marked early beats). Quinidine has depressed the atrial flutter rate down to the atrial tachycardia range. Atrial flutter is rarely associated with digitalis intoxication. Carotid sinus massage rarely converts atrial flutter but usually causes atrioventricular block so the flutter waves can be more easily seen. Both re-entry and ectopic mechanisms have been postulated for atrial flutter. Symptoms were often due to the underlying heart disease. Our patient was in congestive heart failure with marked left ventricular dysfunction manifested by a MUGA ejection fraction of 18%. An increase in his digoxin caused further slowing of the ventricular rate. As digoxin is increased to treat atrial flutter, the ventricular rate often becomes irregular when more of the atrial flutter waves are blocked at the atrioventricular node. Subsequently, our patient converted to normal sinus rhythm and his heart failure improved. The QRS axis is leftward because the QRS lead II (middle strip) is more negative. This suggested left anterior hemiblock. ◀

SOLVE YOUR PROTECTION PUZZLE

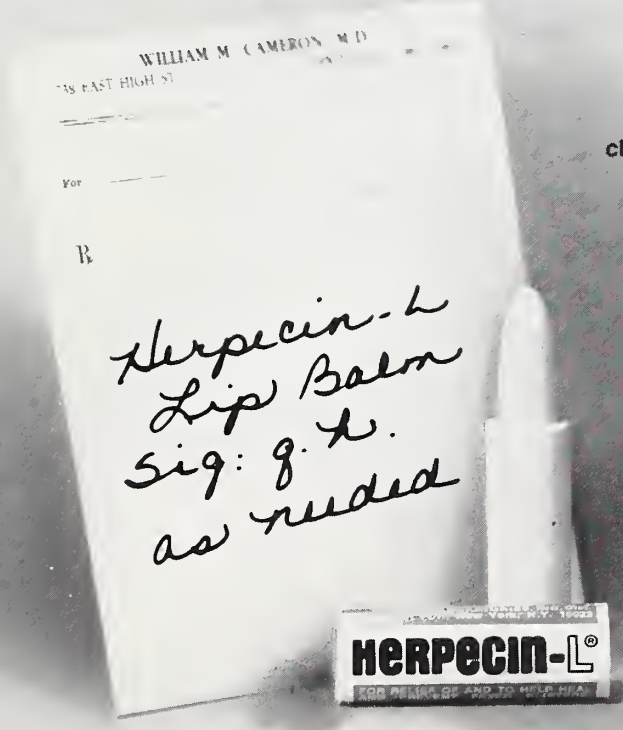
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OTC. See *P.D.R.* for Information.
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JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

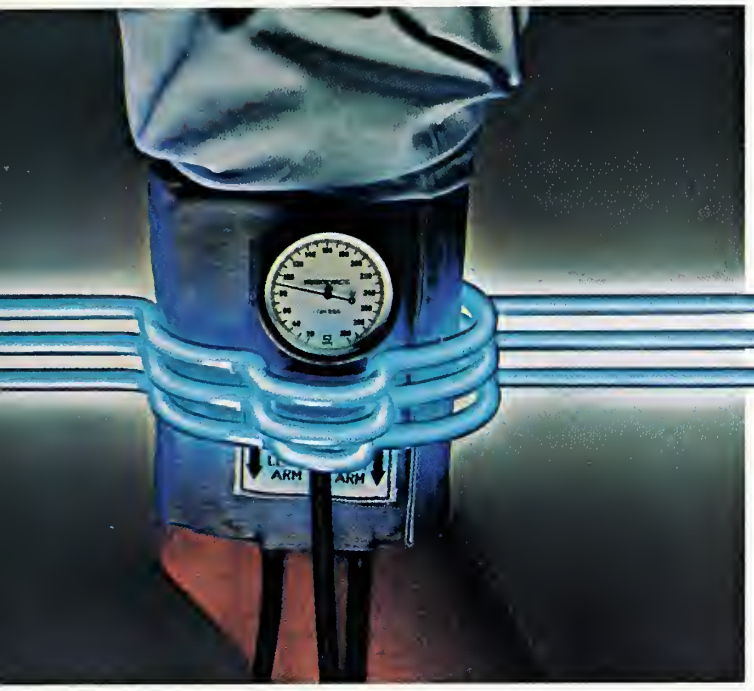
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



THE ONE™ TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

Ayerst®

The one to count on for HYPERTENSION, ANGINA and prevention of MIGRAINE.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8688/883

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

A Second Opinion

In July we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

You Get What You Pay For

Dear Editor:

It would appear as though I'm bragging on the 10 o'clock Coffee-Break Round Table, if I quote from another happening there. Since it may never happen again, I'll go on with the braggin'.

It was Monday last, and the excitement level picked up when Chauncey pulled up a chair, set his mail bag down, fished several envelopes out and began going through the contents. I remember well how he crammed and then cribbed to pass the entrance exam, but now Chauncey is an accepted authority. Not too surprising, considering that he is one of the few citizens of our town wearing a uniform daily and the only one who drives a car with the steering wheel on the wrong side. Authorities have been acknowledged with lesser credentials!

The level of excitement trailed off when we realized that he was opening his own mail and mostly bills at that, but sure as sin, if Chauncey had something to say, it would be worth the listen. Turned out he focused all his attention and wrath on the bill for his auto insurance premium, which had practically doubled in the last two years. A terrible state of affairs, said Chaunce! Chic, who sells most of our insurance in town, jumped on that one, pointing out all the protection and benefits gained for that premium. Well, Chauncey rose to that, saying that he'd been driving and delivering for 20 years, hasn't had scratch one and all of that from the right hand seat! Seemed as though he was being punished for something he hadn't done, and punished through the most sensitive part of his anatomy, his wallet! (A non-medical opinion, I hasten to add).

Well, after the nods slowed down, old Asa opined that what Chauncey had said was correct—for Chauncey.

Old Asa had never thought he needed insurance. Drove team and car without it for years. Then he put his pickup over the hill and was the loser for that as well as the tab for three weeks in the hospital. Old Asa does have a way of bringing us all back to earth!! But Chauncey got right back in the saddle when he chastised all us lesser beings and pointed out that you only get what you pay for, whether you pay for it before you need it or after you get it. Pretty profound, even for Chauncey!!

Well, as I said, that little vignette must have been in my head when perusing the *IMJ, et al.,* (as you medical writers say) in which I noted comments re increases in premiums, dues, etc. Not wanting to 'out-profound' Chauncey, I'll borrow from a commercial on TV. "You can pay for it now, or you can pay for it later."

From the value I see, and remember that I am only an observer, (uninformed, but objective) your members get a lot of value—now and in the future, for what they pay for now.

With best regards to you, and thanks to whomever is in charge of misdirected mailings. I do enjoy reading the doctors' views of things within that profession and their sense of what's happening in the rest of the world.

Ys truly,



Emerson Goodwins.

The Viewbox

CONTRIBUTING EDITOR TERRENCE DEMOS, M.D., ASSOCIATE PROFESSOR OF RADIOLOGY,
DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Kathleen A. Gadwood, M.D., assistant professor of radiology and Terrence C. Demos, M.D., associate professor of radiology, department of radiology, Loyola University Stritch School of Medicine.



Figure 1
Retrograde pyelography shows a normal left ureter, but there is fusiform dilation of the distal right ureter which tapers to a point at the ureterovesical junction. The ureteral catheter passed with ease into the unobstructed distal ureter.

This healthy 9-year-old boy was brought to a physician because he had enuresis. An excretory urogram was normal except for dilation of the distal left ureter. This abnormality was investigated by cystoscopy, which was normal and retrograde pyelography shown here.

Your diagnosis?

(1) Vesicoureteral reflux
(2) Primary megaureter
(3) Diabetes insipidus
(4) Urinary tract infection
(5) Peritonitis

(Continued on page 228)

Pulse of the ISMS Auxiliary

Health Projects

By Susanne Webb, ISMSA President

Most of the services and benefits that an auxiliary provides for its local community come under the heading of health projects. Even scholarships can be so considered, since they result in the production of health care providers.

Project Bank is an invaluable resource in planning a project. An auxiliary surveys its community or county and recognizes a need. The Project Bank catalog is then consulted. The listings are grouped in 15 major categories and 90 subcategories.

There are projects that can be done by one or two people and others involving coalitions of hundreds. Once a project is decided upon, it is ordered on a request form by catalog number. When received, the package contains step-by-step information on how this project was done in the county where it originated. These projects always can be adapted to special circumstances in your area.

Project Bank is not just a storehouse of information for withdrawal. Every county is urged to make deposits. We have so many auxiliary members who are intelligent and creative and come up with new ideas for innovative projects. These should be sent in so that as the catalog is continually updated they can be shared by auxiliaries nationwide.

This year the AMA Auxiliary is focusing on children and youth under the Shape Up for Life umbrella with an emphasis on child abuse and neglect and a concern about drunk driving. At the AMAA convention, Illinois presented a resolution concerning the need for education on the problems involved in adolescent pregnancy and the need to get information on the alternatives available to the young people.

In line with these objectives, we are planning on a speaker from the Illinois Secretary of State's office at the leadership seminars. That person will tell us the current status of drunk driving laws, give us some statistics on the extent of the problem and ideas on how we can help to alleviate it, either as individuals or as auxiliaries. Our health projects chairman, Suzanne Meirink, has a survey on teenage driving and drinking that is given to both teenagers and their parents. The results have proved most interesting. County chairmen might want to consider this.

At Fall Conference we are planning to have an expert speaker on the problems involved in adolescent pregnancy. That speaker will describe the scope of the problem and give ideas on how we can help to educate our communities in this area.

I would also like to start another coalition project, in conjunction with the American Cancer Society, to distribute breast self-examination pamphlets. This is an easy project but so worthwhile. It brings about early detection and dramatically improves the chances for cure. This is also an opportunity for our members-at-large to participate actively in an auxiliary project.

We are updating our immunization pamphlet. Preventive medicine is always preferable. This again is an easy project (taking the pamphlets to the schools) and it results in very good public relations for the auxiliary. It lets the community see that we care and can contribute to its continued well-being. Let's change our stereotyped image so that we are perceived more accurately as the multi-talented and compassionate people that we are. ◀

Illinois Society, American Association of Medical Assistants

American Association of Medical Assistants 27th Annual Convention Preview

By Lesa B. Greene, CMA-C

Each year, the American Association of Medical Assistants (AAMA) holds a national convention in a different city. The 27th annual convention, from October 10-14, 1983, will be held in New York City and promises to be as exciting as its host city.

Plane fare from Chicago to New York drastically ranges in price, so it is important to shop around for the most economical air rates. Modern Travel Service, 55 East Monroe, Suite 4315, Chicago, Illinois, 60603, has been named the official convention travel agent, and as such will arrange for AAMA members to obtain the best possible air fare.

The Sheraton Centre, 7th Avenue at 52nd Street, New York City, New York, 10019, 212/581-1000 will serve as the AAMA's headquarters hotel. (Reservations received after September 16, 1983 will be subject to availability.)

Advance individual registration was available until September 13, 1983. After that date, registrations will be processed only at the convention, and an increased fee will apply.

Several educational sessions will be offered during convention week. Three of these will be non-CEU credit general sessions. These are titled: (1) "AAMA Approaches Its Future," (2) "Recent Advances in Management of the Patient with Coronary Artery Disease: Radionuclide Cineangiography," and (3) "Making Your Association Work for You!" Educational sessions that have been approved for CEU credit include the following: (1) "Visual Media and Teaching Techniques of the 80s," (2) "Computers: Now or Later?" (3) "New Diagnostic Technologies," and (4) "Drugs: Research, Action and Reaction."

This convention will afford medical assistants opportunities to exchange information, develop their knowledge base, and secure a compendium of useful material.

Information regarding this convention and/or the Illinois Society, AAMA, may be obtained from Betty Kronemeyer, CMA, president, Illinois Society, 809 North 10th Street, Mascoutah, IL., 62258, or Lesa B. Greene, CMA-C, chairman, Public Relations Committee, 8836 West Grand Avenue, River Grove, IL., 60171. ◀

ISMS 1984 TRAVEL PROGRAMS

January 22-29—*Virgin Islands Cruise*
St. Thomas, Tortola, Norman Island, Virgin Gorda, Jost Van Dyke and St. John

March 4-19—*South Pacific*
Australia, New Zealand and Tahiti

May 5-16—*Spain/Portugal*
Lisbon, Seville, Costa del Sol and Madrid

May 29-June 11—*Europe*
Munich, Strasbourg and Lucerne, including the 350th Anniversary Performance of the Passion Play at Oberammergau

July 7-14—*New England/Cape Cod Cruise*
Boston, Plymouth, Nantucket, Martha's Vineyard, Newport and New Bedford

August 13-25—*Russia*
Helsinki, Moscow, Vladimir/Suzdal and Leningrad

September 9-23—*Far East*
Tokyo, Kyoto, Singapore, and Hong Kong

October 12-26—*Danube River Cruise*
Austria, Czechoslovakia, Hungary, Yugoslavia, Romania, Bulgaria, Russia and Turkey

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS and auxiliary members at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators.

For further information, please contact the travel department at ISMS headquarters.

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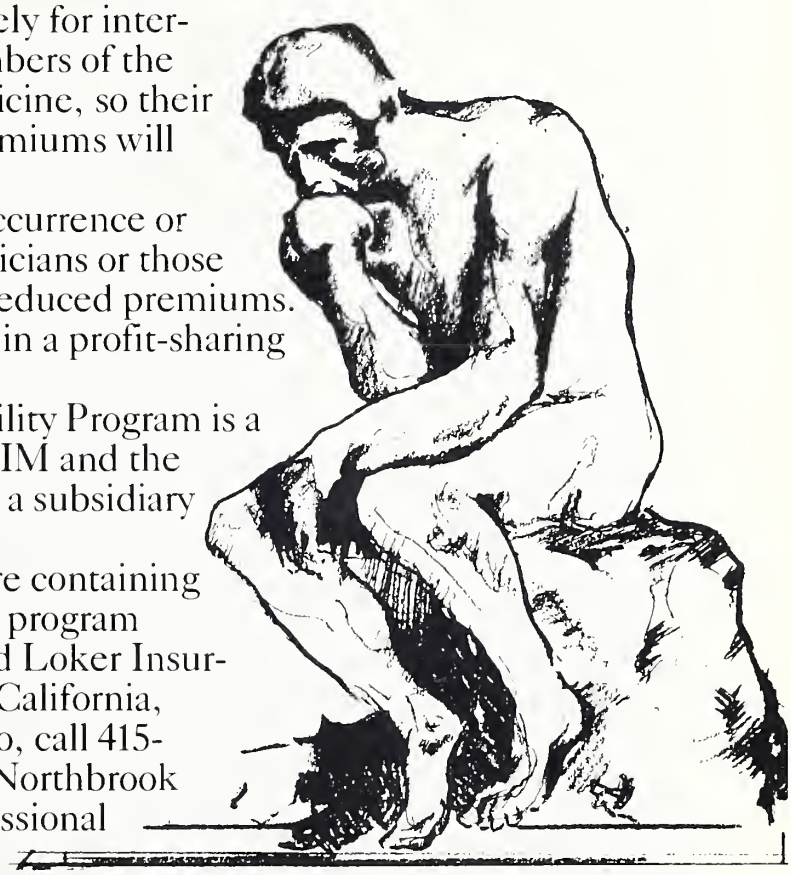
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Conservative Management

Blunt Traumatic Splenic Injury

By Linda B. Uthoff, M.D., Ben C. Berg, Jr., M.D.
and Carl S. Adams, M.D./Peoria

Immunologic compromise with subsequent risk of overwhelming post-splenectomy sepsis mandates thoughtful management of splenic injury. One hundred and thirty cases of splenic injury treated during the past five years at an active regional trauma center were reviewed. Of these, 36 documented splenic injuries of various types were managed conservatively, both operatively and non-operatively. This paper focuses on these cases and their follow-up.

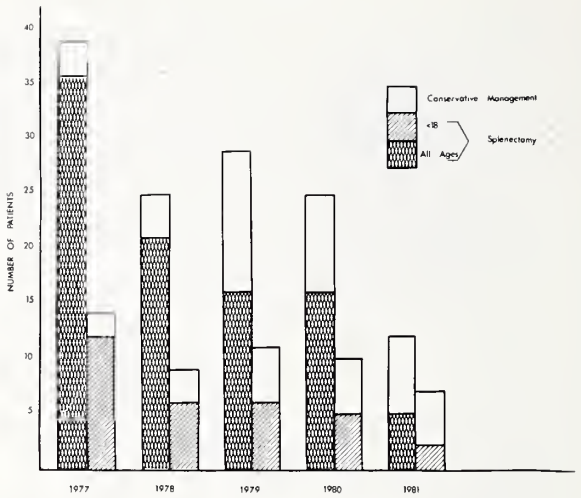
Any splenic injury, however small, classically calls for splenectomy as standard therapy. That determination is supported by reports of high mortality in the early 1900s with non-operative management. Since 1952 when King and Schumacker[1] reported a link between prior splenectomy and a syndrome of overwhelming sepsis, treatment of the patient with splenic injury has undergone a slow metamorphosis. Palliation in the form of immunization and antibiotic prophylaxis of splenectomized patients graduated to actual splenic preservation, first with reports of successful splenorrhaphy in 1962 by Campus Christo,[2] then with reports in 1971 of successful non-operative management by Douglas and Simpson at the Hospital for Sick Children in Toronto.[3] Immunologic sequelae from splenectomy result in the greatest risk of sepsis in children less than two years of age.[4] Established data shows increased risk to older individuals of sepsis and possibly coronary artery disease after splenectomy. Thoughtful management of splenic injury is required in all age groups.[5] With these facts in mind, a retrospective review of management of splenic trauma was undertaken at a designated regional trauma center in a community hospital. Trends and techniques in management and success and safety of conservative treatment were assessed.

All cases of blunt splenic injury admitted to St. Francis Hospital-Medical Center, Peoria, Illinois, in a five-year period from January, 1977 through January, 1982 were reviewed. Twelve general surgeons participated in the care of these patients. As presented in Figure 1, a total of 130 cases were identified. Of these, 94 underwent splenectomy. Thirty-six patients received conservative surgical

Figure 1

YEAR	CONSERVATIVE MANAGEMENT			SPLENECTOMY
	Non-op.	Op. repair		
1977	1	2		36
1978	2	2		21
1979	12	1		16
1980	7	2	*2/3 <18	16
1981	6	1	+1/3 <18	5
Tot.	28	8		94+
	36*			

Figure 2



management or non-operative treatment; these will serve as the point of focus. Of these 36 patients, 20 were children less than 18 years of age with a range of 24 months to 18 years. Six patients had splenic injuries alone. The remaining 30 patients had associated injuries consisting of renal lacerations and contusions, vertebral, rib, pelvic and extremity fractures, pneumothorax, head injuries, scalp lacerations and pulmonary contusions. Clinical suspicion of splenic injury confirmed in each case by nuclear scintigraphy was the basis of diagnosis. The reliability of nuclear scanning at this institution has been established with a high degree of confidence based on correlation of scans with operative findings in cases of splenectomy.[6] Scintigraphy was available on a 24 hour basis and diagnosis was made by nuclide scanning in 92% of cases within 12 hours of admission. Scintigraphy performed with a small and large field of view scintillation camera includes routinely a posterior, anterior, right and left lateral, RAO and LAO views. Additional views as LPO and RPO can be added at the discretion of the radiologist. For an average-size patient, each view takes 1.5-2 minutes. Freeze dried Technetium 99m sulfur colloid is used, with a five minute preparation time. Follow up in 75% of the cases was available by review of post discharge liver-spleen scans or physician office visits.

Results

Eight patients underwent operative repair of splenic injury, seven of whom had surgery the day of admission. Hemoperitoneum ranging from 100 to 500cc was found in six of the eight patients. Two patients required blood replacement (500cc each). None of these eight patients had other intra-abdominal injuries requiring surgical repair. The splenic injuries included a superficial capsular tear treated with cautery, single or multiple lacerations controlled with microfibrillar collagen, (0.5-1gm) a laceration of the lower pole repaired with suture of the capsule and microfibrillar collagen application. Stellate fragmentation of the lower pole was repaired by segmental resection, interlocking mattress suture and microfibrillar collagen. Operating time ranged from 20 to 60 minutes (average 40 minutes). Follow up ranging from three weeks to three years reveals no instance of re-bleeding or sepsis.

Twenty-eight patients were managed non-operatively, and of these, 11 required transfusions of an average of 550cc of blood with a range of 220cc-1,250cc. Average hospital stay was two weeks. Follow up averaging two months (one week-28 months) showed no instance of delayed rupture or sepsis. Twelve patients had repeat splenic scintigraphy one week to eight months post injury. In all cases, repeat scintigraphy showed improvement of the original injury with either persistence of minor defects or complete resolution of the original traumatic deformity. There were no instances of a worsening deformity or splenic cyst formation.

In comparing the number of conservatively treated patients with the number of total patients with splenic injuries (Figure 2), a trend toward conservative management is identified, especially in patients less than 18 years of age. The record for such conservatism is zero mortality. It is to be noted that this reflects careful practice and sound judgment. Of those patients conservatively treated, all but six had cardiovascular stability at initial evaluation. Six patients with systolic blood pressure below 100 or pulse greater than 110 were quickly stabilized with fluid resuscitation. Management as

Table I
Protocol For Non-operative Management

* Diagnose splenic injury on the day of injury
* Admit to an intensive care area
* Place a large bore IV and levine
* Order strict bed rest
* Have blood on hold until the HCT stabilizes
  —order serial HCT's q 4° × 24° then q 6° × 24° then q 12° × 24° depending on the patient's clinical condition
  —transfuse blood if HCT <30
* Measure abdominal girth serially in young children
* Repeat splenic scintigraphy in 12-24° to assess the stability of the splenic injury
* Move the patient to a general floor after the HCT stabilizes
* Allow p.o. feeding as the ileus resolves
* Increase activity at 5-6 d to sitting in a chair and at 7-10 d to quiet walking if no LUQ pain
* Discharge at 10-14 d if repeat HCT and splenic scintigraphy are stable.
* Instruct the patient at discharge to engage in quiet home or outdoor activities for 4 weeks, after which he may return to school or work.
* Repeat scintigraphy if the patient develops any LUQ pain or shoulder pain
* If routine repeat scintigraphy at 6-8 weeks shows a stable or completely resolved defect, the patient is allowed to return to full activity including athletics.

outlined in Table I and similar to that reported in other centers[7] included attention to ready availability of blood for transfusion, serial hematocrits, strict bed rest, intensive care observation, frequent re-examinations, and repeat scans to assess change in splenic injuries. Such careful management will help to ensure continued safety with conservative management.

Discussion

In 1952 a warning sounded suggesting an important immunologic function of the spleen when King and Shumacher at Indiana University[1] reported death from sepsis in all five infants less than six months of age who underwent splenectomy for congenital hemolytic anemia. In children splenectomized for trauma, reports of serious subsequent sepsis first appeared in 1957.[8] Singer's collective review[9] estimates this risk of severe sepsis to patients with prior splenectomy for trauma at 0.58%, 58 times that of the normal population.

Overwhelming sepsis in splenectomized patients stems from the absence of antibodies or opsonins normally produced by the spleen which are necessary in promoting rapid digestion of bacteria. With splenectomy, the loss of both opsonin production and the spleens' reticulo-endothelial function results in a reduction of the clearance of blood-borne bacteria, and overwhelming sepsis can result. Partial splenectomy or splenic repair best averts these immunologic sequelae,[10-12] although some recent evidence using an animal model suggests that transplantation of splenic fragments into the omentum may also preserve some immunological function.[13] Reluctance to practice splenic salvage stemmed from fear of delayed rupture and reports of high mortality in the early 1900s. These fears appear unfounded, and more recent series show no instances of delayed rupture.[14,15] In addition, follow up examinations with nuclear scintigraphy show the natural course of splenic injury to be one of either complete healing or residual stable defects.[16,17] Several series attest to the fact of safety in conservative management with either operative[18-23] or non-operative[16,17,24,25] management. Our series adds 36 cases successfully and safely managed.

Conclusion

One hundred and thirty cases of blunt abdominal splenic injury were reviewed with special attention directed to 36 cases treated conservatively. Diversity of surgical care led to operative repair in eight patients and nonoperative management in 28. In both groups, mortality was zero, and there was no instance of delayed rupture or sepsis in follow up. A trend of increasing splenic salvage especially in children during the past five years is identified.

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A complete list of references for "Blunt Traumatic Splenic Injury," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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Massive Lower Gastrointestinal Hemorrhage In Crohn's Disease

By George Mesleh, M.D. And James Lemons, M.D./Oak Lawn

Crohn's Disease is mentioned in most text books as an infrequent cause of massive lower G.I. hemorrhage. In this report we seek to bring attention to this possibility, its frequency and pathology as well as the accepted therapeutic modality.

We report of a case which brings the number of well documented cases in the literature to 27.

Papers reviewing the etiology of massive lower gastrointestinal hemorrhage ordinarily mention that diverticulosis constitutes about 75% of all causes. A long list of different causes often follows. Crohn's disease is frequently missed.

Complications of Crohn's disease include abscesses, fistulas and strictures. Lower G.I. hemorrhage is not frequently mentioned; a review of the English literature found only 26 well documented cases.

This case is believed to be among the few reported in which massive lower G.I. bleeding was the first clinical manifestation of Crohn's disease and also one of the few (second to our knowledge) in which an arteriogram was to localize the site of bleeding before undertaking surgical intervention.

The patient was a 26-year-old previously healthy white male who was admitted via the emergency room of our hospital because of massive painless lower G.I. bleeding that started 12 hours prior to admission and had been getting more severe. Patient felt dizzy and decided to come to the emergency room.

The patient did not complain of abdominal pain, nausea, vomiting, tenismus or previous episodes. He was not on any medication and had never been in the hospital.

The family history was significant. The patient's father had had carcinoma of the left colon resected in our institution three months prior to the patient's admission.

On physical examination, the patient looked pale with blood pressure of 90/60 and a pulse of 110. His general and abdominal examination were essentially normal and much fresh blood with clots flowed from the rectum. NG tube was inserted and the return was clear.

The initial hemoglobin was 8gm. Bleeding time and coagulation profile were normal.

After initial resuscitation the patient was transferred to the surgical intensive care unit. Proctosigmoidoscopy did not reveal a site of bleeding.

After transfusing five units of blood in six hours, rectal bleeding continued and Hgb stayed around 6gm.

An aortogram with selective catheterization of the S.M.A. revealed extravasation of the dye (Figure 1) that persisted during the venous phase (Figure 2) in the early ileal branches of the S.M.A.

Patient continued to bleed massively during and after the arteriogram. Emergency laparotomy was performed. A localized area of typical Crohn's disease with thickened wall and creeping mesenteric fat was seen at the beginning of the ileum. It measured about 12cm in length and there were no other areas involved. No colonic lesions were noted. The area was resected and primary end to end anastomosis performed.

On opening the specimen, there was an ulcer

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Figure 1



Figure 2

measuring 2 × 0.5cm with a blood clot at the center (Figure 3). The wall was uniformly thickened, microscopic examination of the small bowel revealed involvement of the whole thickness of the bowel wall with non-caseating granuloma typical of Crohn's disease. (Figures 4 and 5).

Patient did well postoperatively with no evidence of recurrent bleeding in five years of follow up.

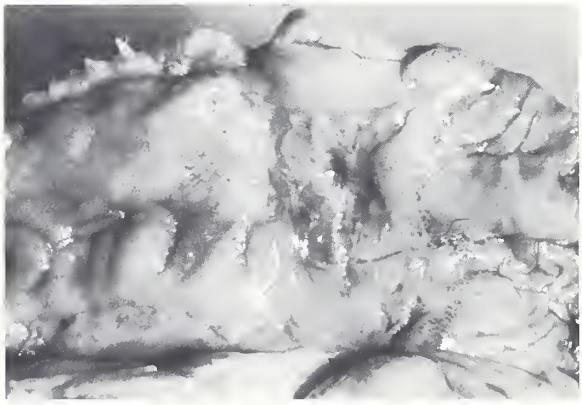


Figure 3

Review of the Literature

Our report brings to 27 the number of well documented cases of massive lower G.I. bleeding in Crohn's disease. The last seven cases were reported by reviewing 503 patients with Crohn's disease at the New York Hospital Cornell Medical Center.[1] A few cases have been reported in the *British Medical Journal*.[2,3] An incidence of 1% has been cited by J. Alexander Williams in a progress report about Crohn's disease.[4] Crohn reported one case in 1939. He considered massive lower G.I. bleeding in Crohn's disease to be atypical,[5] but in 1958, reviewing his 542 patients, he added one more case.[6] Other cases have been reported since then.[7-12]

The true incidence of massive lower G.I. bleeding in Crohn's disease may be higher because many cases are not reported and because massive lower G.I. bleeding is usually initially managed conservatively. This was especially true in the 1960s. Many patients stop bleeding with no definite diagnosis.

The incidence of occult rectal bleeding in Crohn's disease is higher. In the New York Hospital series, 31% had evident rectal bleeding on examining the stools for blood.[1] In the progress report by J. Alexander Williams, it was found that 60% of 300 patients with Crohn's disease had iron



Figure 4



Figure 5

deficiency anemia. Of the patients with small bowel disease, 15% had occult rectal bleeding. Of the 171 patients with Crohn's disease of the large bowel, 52% had occult rectal bleeding.[4]

Many patients reported in the literature are known to have Crohn's disease and they present with massive lower G.I. bleeding during its course (six out of seven cases in New York Hospital series[1]). However, many patients present with massive lower G.I. bleeding as the first manifestation. This is especially true in young adults. Crohn's disease is probably the third most common cause of massive lower G.I. bleeding in young adults (after congenital vascular lesions and Meckel's diverticulum).

Peptic ulcer disease is present in about 5% of cases of Crohn's disease.[10] It is important to rule out peptic ulcer as the source of G.I. bleeding in Crohn's disease patients.

There is no relation between the duration of the disease and the incidence of massive lower G.I. bleeding.

In reviewing the literature we found more cases of bleeding in Crohn's disease involving the small bowel. This reflects the usual distribution of Crohn's disease as more common in the small bowel.

When reviewing the pathology of Crohn's disease, we found multiple ulcerations extending to the submucosa or even deeper. The incidence of bleeding is low. This is probably due to the surrounding edema and fibrosis with transmural involvement which prevent erosion in the blood vessels. This is in sharp contrast to ulcerative colitis, where there is massive bleeding from the mucosal ulceration.

As to therapy, opinion is divided. In the seven cases reported by New York Hospital, no recurrent bleeding occurred in a follow-up period of up to eight years. However, two cases reported by the University of Chicago[10] had recurrent bleeding after the surgical resection.

It is logical to assume that lower G.I. bleeding in Crohn's disease is, like the disease itself, unpredictable. Recurrence in Crohn's disease with or without bleeding after surgical therapy is frequent.

The same principle for the management of

Crohn's disease should be followed. Conservative management that includes blood transfusion is the main route. Steroids may play a role.[10] Angiography and vasopressin infusion if massive bleeding continues are indicated. Surgery is reserved for life threatening hemorrhage that does not respond to these measures.

Summary

The case of a young adult with Crohn's disease manifesting itself for the first time as a massive lower G.I. bleeding was presented. The bleeding site was localized by angiography. Surgical resection was curative on five year follow up. On review of the literature we concluded several facts: (1) massive lower G.I. bleeding from Crohn's disease may be more common than reported; (2) Crohn's disease should be kept in mind as one of the causes of massive lower G.I. bleeding in young adults; (3) recurrence after surgical therapy is common and (4) For the above reasons, conservative management is indicated and surgery is reserved for continuous life threatening hemorrhage, frequent recurrent massive bleeding or other indications for resection.

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The Emergency Therapy of Burns of the Eye

By Eduard Poser, M.D./Chicago

The use of water to wash out acid or alkali splashes from an eye is often not as reliable or effective as the use of a buffer. Injury that may result from these splashes is consistent with the type of chemical, its velocity on striking the cornea, its concentration and also its length of contact.

The emergency care of these accidents requires prompt removal of both the dissociated and undissociated parts of the chemical. Strong chemicals like hydrogen chloride (HCL) and sodium hydroxide (NaOH) dissociate into ions completely. The tissue injury caused by these ions continues until they are either removed by irrigation or accepted and thus neutralized by the buffers in the tissue. The latter, of course, results in consequent injury. A somewhat similar condition may prevail with a weak chemical like acetic or lactic acid, which does not dissociate into ions completely. Here the undissociated part may also penetrate and likewise must be removed before injuring the corneal tissue. When these chemicals splash onto corneal tissue the pH of its cells is altered because of the reaction of the cations or anions with water in the cells. The anions of a basic chemical remove the protons of the tissue water which increases the concentration of the $\overline{OH}$ ions. Similarly, the cations of an acid give up protons. The extent of this hydrolysis (or in this instance proteolysis) depends on the factors previously mentioned. When these chemicals are not quickly removed, the amphoteric proteins of the cornea become denatured, causing corneal opacities. Some heat is developed in both the neutralization and dilution processes. However, this is of minor importance compared to quick elimination of the poison. Fewer of the reactions mentioned above occur when a buffer is used as the irrigation solution. In that case, the injurious chemical is quickly neutralized and the tissue cell pH is restored to the physiological level.

Partly because of its availability, water has customarily been used to irrigate a conjunctival sac which has been assaulted by these chemicals. However, water does not rapidly remove the layer of chemical adjacent to the cornea. That failure is due to adhesive qualities of the surface and the lamelar flow of the water over a surface. This layer is the most important because it is next to the corneal tissue. The hypotonicity of water also tends to draw some of the chemical further into the corneal stroma, while in addition a lid spasm may make adequate irrigation difficult or impossible.

Tears which normally wash over the cornea have a pH of 7.4 and consist of albumin, globulin, lysozyme, sodium chloride and bicarbonate. Their buffering qualities are too weak to cope with strong chemicals. Aid to the cornea must come from outside the eye itself.

Either acids or alkalis may denature proteins. The extent of their destruction is in proportion to factors previously mentioned. However, their methods of destruction are different. Acids first change the pH of the tissues to be similar to their own. They next enter into a chemical reaction with the cell water and then the protein and other constituents of the cell. A precipitate may then be formed and dissolved, depending on the concentration and other characteristics of the chemical. Alkalis, especially those with potassium (K) and sodium (Na) ions, are very caustic. Postassium hydroxide (KOH) is more caustic than sodium hydroxide (NaOH) because the K ion penetrates the cell more readily. They likewise change the pH of the tissue to correspond to their own. However, they also react with the lipids in the cell wall to form soap. Thus the kinetics of the cell wall, which formerly could effectively bar the passage of hydrophilic molecules, are changed so that the cell membrane can no longer regulate its metabolic requirements.

The treatment here is essentially the same as with an acid injury: quick elimination of the chemical. The buffer is better to accomplish this because it can be used both for irrigation and neutralization, which is of the utmost importance in the event of a lid spasm. For this reason, it has a far greater safety factor than water. A drop or two of castor oil in the eye may be used later: any remaining caustic might form soap preferentially from that source and save any cell lipids from further injury. Such a hypertonic buffer is also useful when delicate tissue is

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injured by non-corrosive, hypotonic dehydrating fat solvents like methanol. Here its hypertonic characteristics cause the tissue to wash out the solvent and thus limit its penetration.

The buffer recommended for irrigation purposes is prepared by dissolving 35 grams of monobasic potassium phosphate (KH_2Po_4) and 90 grams of dibasic sodium phosphate (Na_2HPo_4 . 12 H_2O) in 850cc of water. The concentration of such a solution is ½ molar with respect to the phosphates which may be used in such high concentration because they are physiologically occurring substances. Their use ensures prompt neutralization without adding new complications. The degree of burn and consequent scarring is limited. This phosphate solution has an approximately neutral pH. Owing to its buffering action, the hydrogen ion concentration of the tissue will quickly return and remain in the physiological range. The fact that it can be used equally well on acids or bases is demonstrated by the following example:

1—$Na_2HPo_4 + HCl$-----$NaH_2Po_4 + NaCl$

2—$KH_2Po_4 + KOH$-----$K_2HPo_4 + H_2O$

This phosphate solution[1] is not only an irrigator but also a buffer. For this reason, it is superior to water and, in addition, it is hypertonic. This is of paramount importance in drawing poisons out of the tissue. It has been proven experimentally that a small amount of buffer in the conjunctival sac protects the cornea to a greater extent than an equal amount of water.[2] Other investigators have proven that a phosphate buffer reduces corneal injury inflicted by alkali burns if used within thirty minutes of exposure.[3]

Alkalis penetrate deeply into tissue and are said to have a prolonged effect because of retention and slow release. For this reason, prolonged irrigation with an isotonic solution lasting up to 48 hours has been advocated.[4] Injection of the patient's blood beneath the conjunctiva has also been advocated, on the grounds that it could act as a barrier against deeper penetration by buffering the chemical that had penetrated.[5] However, such treatments cannot be considered emergency because of their late administration. That theory apparently neglected to note that the tissue itself is able to buffer even to its own detriment. Therefore, it is preferable to use the hypertonic buffer immediately because its buffering action creates a safety factor that water does not have and also because its hypertonicity tends to draw the poison from the tissue.

Summary

Buffers are utilized by all living tissue. For example, blood contains two main buffering systems: the bicarbonate located mostly in the plasma and the non-bicarbonate hemoglobin in the red cells. Phosphates are also used by the tisuse. From a biological viewpoint, buffers are important because they protect the chemical processes of living cells, which are extremely sensitive to changes in pH.

Denaturation is an irreversible precipitation of tissue proteins caused by acids, alkalis, other chemicals and heat. Thus the physiological function of the proteins is destroyed. Therefore, prompt irrigation is the only treatment for these injuries. A hypertonic[6] buffer may serve as the safety factor by preventing denaturation, ensuring less injury with less scar tissue and favorably affecting vision.

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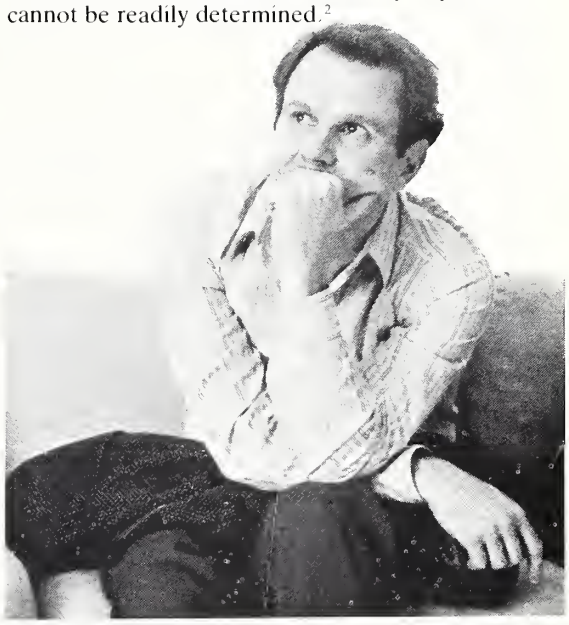
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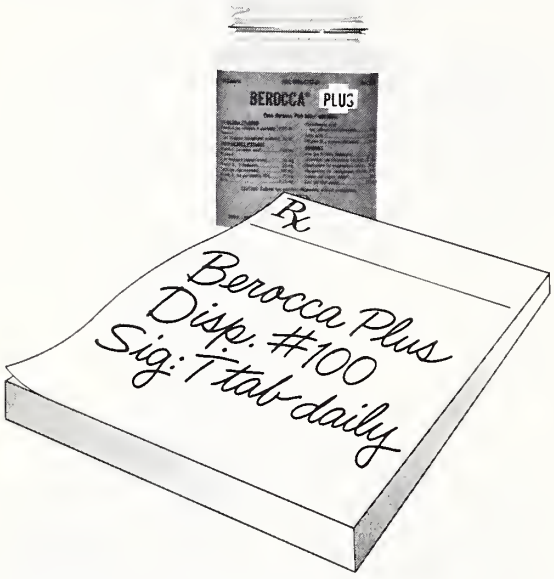
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Case Reports

Bilateral Whole Thorax Irradiation For Metastatic Tonsillar Carcinoma

By Tae Soo Chung, M.D./Hines

A patient with squamous cell carcinoma of the tonsillar pillar with neck nodes and multiple bilateral lung metastases is reported. The patient was treated with radiation to the primary tumor, neck nodes and whole thorax and survived for 38 months without evident recurrence.

The lung has been proven to be the most common site of distant metastasis from tonsillar carcinoma.[1] When a solitary metastasis is discovered a long time after control of the primary tumor and the primary was rectal, urethral, cervical or testicular, some long term survivals can be expected by wedge resection in selected cases.[2] However, when the metastases are multiple and involve both lungs, patient management is difficult. The author reports a patient with multiple lung metastases from tonsillar carcinoma who was treated with whole thorax irradiation with no evidence of disease for 38 months.

Tae Soo Chung, M.D., is a board certified radiologist affiliated with the Hines Veterans Administration Hospital. Dr. Chung specializes in therapeutic radiology and also serves as the assistant director for the Hines residency program in that area. He is a clinical assistant professor of radiology at the Chicago Medical School and a member of both the American Society of Therapeutic Radiologists and the Radiologic Society of North America.

Case Report

A 62-year-old white male with history of double aortocoronary bypass surgery was admitted to the thoracic surgery with suture abscess. Routine physical examination revealed an ulcerative lesion at right tonsillar pillar extending to adjacent base of the tongue. There were no neck nodes palpable. Chest X-ray and SMA-12 were within normal limits. Biopsy of the lesion one week after admission showed "poorly differentiated squamous cell carcinoma." A month later, the patient was referred to radiation therapy for the treatment. On examination, there was a lesion at the right tonsillar pillar extending to the right tonsil, retromolar trigone and adjacent base of tongue. Two mobile nodes were palpable at right upper and middle neck. The tumor was staged as $T_2N_1M_0$ (American Joint Committee Staging) and a curative course of radiation therapy to the primary tumor and neck nodes was begun. The patient tolerated the treatment well with complete regression of the neck nodes. Eight weeks later the patient started to complain of cough and general weakness. A chest X-ray was repeated and showed an area of irregular infiltration in the right lower lung field. Whole lung tomogram revealed "multiple bilateral lung metastases." The treatment plan was changed from curative to a palliative course delivering 5,940 rads to the primary tumor and neck nodes in 33 fractions over 46 days. Since the primary tumor and metastatic neck nodes were completely controlled, a palliative course of whole thorax irradiation was started four months after first admission and the patient received 1,820 rads (without lung correction) in 13 fractions over 15 days to the midline of the whole thorax using a Cobalt 60 teletherapy machine.



Figure 1



Figure 2

Figures 1 & 2
Two different levels of whole lung tomograms show bilateral multiple lung metastases.

The patient again tolerated the radiation therapy very well with complete relief of symptoms. A repeat whole lung tomogram revealed almost complete regression of the metastatic deposits except for a few scattered nodules over both lung fields at the end of the treatment. The patient was followed on a regular basis with periodic chest X-rays, whole lung tomograms and metastatic work-up. This included SMA12, liver and bone scans, which failed to show recurrence in either primary or metastatic areas.

One year after first admission, during follow up examination, the patient was found to have an indurated area at anterior floor of the mouth. Biopsy of this area showed squamous cell carcinoma *in situ*. Surgical excision was done and the lesion was completely excised. Five months later, the patient was admitted to the hospital with complaints of cough and general weakness. On physical examination there was no evidence of disease at tonsillar region, floor of mouth and neck. Chest X-ray revealed a questionable area in the right upper lung. The patient was treated symptomatically and conservatively without improvement and died two weeks later. Autopsy revealed no evidence of malignancy except a scar in the right upper lobe of lung. The cause of death was "bronchopneumonia."



Figure 3
Follow up whole lung tomogram after radiation reveals no evidence of disease.

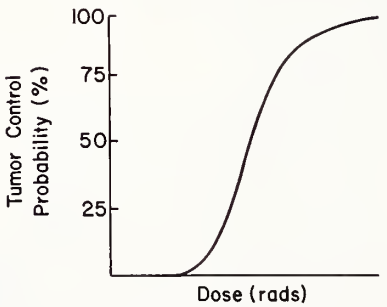


Figure 4
Radiation dose—response curve.

Discussion

Whole lung irradiation for metastatic lung tumors has been reported by several authors.[3-8] Patients with radiosensitive tumors, such as Wilms' tumor, Ewing's sarcoma or testicular tumors, included several long term survivors. However the results of whole lung irradiation for the epithelial tumors are discouraging.[5,6,8] The main problem with whole lung radiation is that one cannot deliver enough radiation to eradicate these kinds of tumors without resulting injury to the lung parenchyma. The tolerance dose of the whole lung is 2,500 rads in four weeks and 1,500 rads in three weeks when Actinomycin D is given either before, during or after irradiation.[5] In contrast, studies have shown that it is necessary to deliver 5,000 rads in 5 weeks to control 90% of microscopic epithelial tumors. However, the sigmoid curve of radiation dose-response shows that there will always be a certain percentage of patients who can be controlled with lower radiation dose. (Fig. 4) The present case demonstrates an exceptional response to whole thorax irradiation within lung tolerance dose, clearly supporting the occasional tumor patient response to low dose radiation. ◀

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Case Reports

Chest Wall Mass With Right Upper Lung Field Opacity

By Michael A. Less And Andrew W. Robbins, M.D./Urbana

A 66 year-old-man presented with a right axillary mass which had been increasing in size over the previous six months (Fig. 1). He had a 120 pack per-year history of cigarette smoking. In 1964, he had undergone a right sided thoracotomy in the treatment of tuberculosis. Physical examination revealed a 7 × 10cm., hard, non-moveable, non-tender mass in the right midaxillary line. Overlying skin was normal. A well healed thoracotomy scar over the right fifth rib was noted. Breath sounds were absent over the right upper lung field. The remainder of the examination was normal. A chest X-ray was obtained (Fig. 2).



Figure 1



Figure 2

Diagnosis

Our diagnosis was subcutaneous migration of paraffin following extra pleural pneumonolysis with paraffin plombage.

The chest X-ray (Fig. 2) revealed a homogenous opacity measuring 8 × 10cm. in the right upper thorax. The inferior border had a smooth convex contour with a thin rim of calcification. A needle biopsy of the chest wall mass yielded only paraffin.

Extra pleural pneumonolysis for the treatment of tuberculosis was first described in 1891. Paraffin was first used to maintain collapse in 1913.[1] Other materials that have been used include fat, muscle, rubber balloons, air, oil, gauze, cellophane, fiberglass, wool, and lucite spheres.[2] Plombage therapy fell into disuse when effective anti-tuberculosis antibotics were introduced.

Some of the later complications that have been reported with extra pleural pneumonolysis and paraffin pack are migration, extrusion through the wound, cold abscesses, fistulae, infections and continued expectoration of small pieces of paraffin.[3] Although this procedure for treatment of tuberculosis has been discontinued, long term complications continue to arise in these patients.

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Michael A. Less is a first year resident in anesthesiology at Michael Reese Hospital in Chicago.

Case Reports

Use of Ultrasound in Evaluating the Large Fetal Head

Intracranial Teratoma

By Kathleen A. Gadwood, M.D. and Carlos J. Reynes, M.D./Maywood

Prenatal ultrasound evaluation of the fetal head is widely performed and numerous pathologic conditions have been diagnosed. We wish to report a case of an intracranial teratoma diagnosed in utero. *This case emphasizes the utility of ultrasound in distinguishing a solid intracranial mass from the more usual case of hydrocephalus as a cause of fetal macrocrania.*

A 28-year-old white female, gravida 2, para 1, was referred for ultrasound examination because she was "large for dates." Gestational age by menstrual dates was 31 weeks and fundal height measured 41cm. Up to this point, her pregnancy had been uneventful. No medications were used except prenatal vitamins, and there was no history of drug, alcohol, or tobacco use. Her first pregnancy resulted in an uncomplicated vaginal delivery of a term infant. Past medical history and family history were unremarkable.

Gray scale ultrasound examination showed a single fetus in breech presentation with a grossly enlarged cranium (Figure 1). The intracranial contents were markedly distorted and no midline echo could be ascertained. Solid and cystic areas were seen, predominantly the former with variable echo intensities. The cystic areas did not resemble a normal or dilated ventricular system. An abdominal film confirmed macrocrania and did not reveal any intracranial calcifications (Figures 2A, 2B).

The patient opted for an expedient delivery and a cesarean section was performed a week following the ultrasound examination. A living male infant weighing 5.0kg was delivered with an enormously large head and no other external anomalies. Apgars were 4 and 3, at one and five minutes respectively, but the child died shortly later in the neonatal area.

At autopsy the head circumference was 59cm and there were prominent veins in the scalp (Figure 3). The intracranial contents consisted of an irregular lobulated mass with no external evidence of cranial nerves or vessels. A small area ventrally sug-

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gested an irregular gyral pattern and a section reminiscent of cerebellar tissue was also seen. Multiple sections revealed fleshy, tan-grey tissue containing microcysts less than one millimeter in diameter and larger cysts measuring several centimeters and containing yellow fluid (Figure 4). Several firm areas had a gritty consistency upon cutting.

Microscopic examination showed disorganized tissue containing elements of ectoderm, mesoderm, and endoderm. Smooth muscle, bone, cartilage, and myxomatous areas were seen. Undifferentiated neural tissue with small Purkinje cells were found, but no evidence of malignant dedifferentiation was found. The pathologic diagnosis was a benign intracranial teratoma.

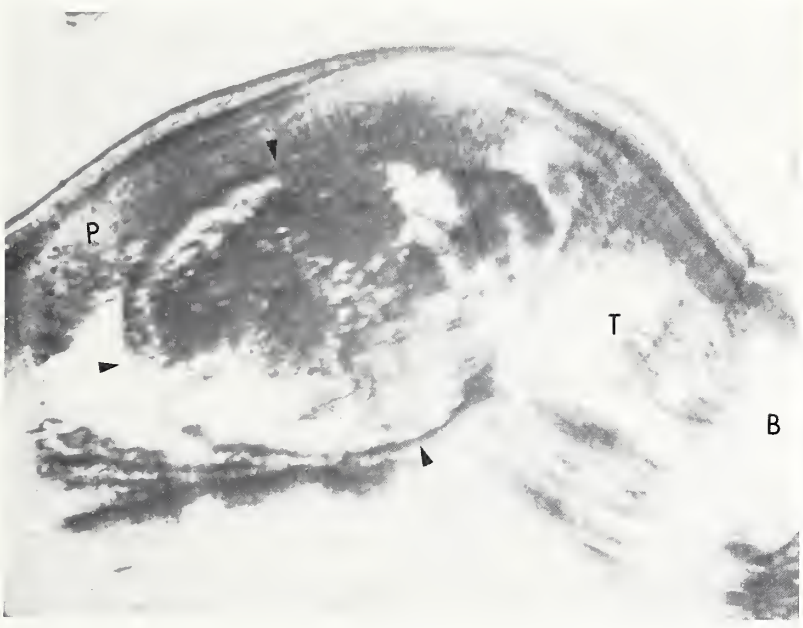


Figure 1
Longitudinal scan. Breech presentation of a fetus with gross macrocrania (arrowheads). Solid and cystic areas are present within the skull without identifiable normal landmarks. (P = placenta, T = fetal trunk, B = maternal urinary bladder). The maternal head is to the reader's left.



Figure 2A



Figure 2B

Figure 2 A-B
AP and lateral views of the maternal abdomen show a large fetal head (arrows) with no definite internal calcifications.

Discussion

The utility of ultrasound in detecting cystic intracranial lesions is well known. Hydrocephaly, hydranencephaly, holoprosencephaly, porencephaly, arachnoid cyst and Dandy-Walker cyst are examples of readily detectable cystic lesions. When macrocrania is present and ultrasound reveals a solid or complex mass with marked distortion of the normal sonographic brain anatomy, teratoma of the brain should be the first consideration.[1-4]

True congenital intracranial tumors are very uncommon. Arnstein reviewed the literature on brain tumors occurring during the neonatal period (birth to 60 days).[5] Thirteen cases were found, five of which were teratoid tumors. The remainder included medulloblastoma, sarcoma, ependymoma and glial tumors. He noted that most of the tumors in the neonatal period were supratentorial, in contrast to the situation seen with childhood tumors where the majority are infratentorial. Although not diagnosed prenatally, Babcock and others have used ultrasound to diagnose echogenic intracranial neoplasms in infancy and Slovis identified a large racemose hemangioma in a three

month old child.[6] Solid neoplasms can be detected by ultrasound if they have a different echogenicity from normal brain or if they cause an obstructive hydrocephalus by mass effect.

Because teratomas amount to only 0.5% of all intracranial neoplasms,[7] large series are rare. In 1940, Sweet reviewed a series of 44 cases of intracranial teratomas. Only four of his 44 cases presented at birth as giant teratoma which replaced most of the brain. Like the case presented here, they were incompatible with post natal life. Beyond the newborn period, intracranial teratomas are usually found in the pineal region, the pituitary region, and the posterior part of the posterior cranial fossa in which case they rarely present clinically until at least the second decade. Interestingly, Sweet found a 2 to 1 ratio of males to females with intracranial teratomas in general, although there may be a female predominance in the neonatal period.[8]

Prior to the era of ultrasound, the prenatal diagnosis of teratoma was difficult. A radiograph of the maternal abdomen showing intracranial calcifications in an enlarged fetal head could suggest the diagnosis. Difficulty often arose during labor because of cephalo-pelvic disproportion. In 1954, Wagner reviewed 10 cases in which fetal intracranial teratomas caused dystocia.[9] In these cases, the skull was either punctured by the obstetrician or burst spontaneously during vaginal delivery. When only a small amount of fluid ensued, the possibility of an intracranial solid mass rather than "hydrocephalus" was entertained. In most cases, the diagnosis was not made until autopsy.

Ultrasound, then, has greatly aided the obstetrician in evaluating the large fetal head. The most basic contribution is in distinguishing a solid or complex intracranial tumor from the more usual case of hydrocephalus. The distinction can aid in planning the mode of delivery as well as affect possible surgical care of the child if a correctable lesion is found. The diagnosis of teratoma can be suggested if there is gross disorganization of fetal brain structure, which is incompatible with postnatal life. Other solid congenital tumors are rare.



Figure 3
Autopsy photograph of the fetal head.



Figure 4
Cut specimen of the fetal brain shows large (white arrowhead) and small (black arrow) cystic spaces intermixed with solid areas. Note resemblance to the ultrasound image.

Addendum

Since submission of this article for publication, a case report of an undifferentiated brain tumor in a fetus has been published. A large fetal head containing solid areas and a single cystic area due to tumor necrosis was seen on ultrasound. Our case of brain teratoma and others described have characteristically had multiple cystic components interspersed with solid elements. It is conceivable that a teratoma could have a single cystic area which would then be difficult to differentiate sonographically from a brain tumor with necrosis. ◀

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CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION – *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE
At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. **8511/783**

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Special Articles

Free Standing Emergency Centers In Illinois

This report was drafted by a subcommittee of the ISMS Council on Medical Services composed of C. Larkin Flanagan, M.D., chairman, Joan Cummings, M.D., Mark Donvito, Adarsh Kumar, M.D., David B. Littman, M.D., Alan Stein, M.D. and Joseph D. Winterhalter, M.D. The report was written under direction of the full Council, chaired by Wallace P. Berkowitz, M.D. Parts of this report, first released in November 1982, have been updated to include new observations of the subcommittee and to reflect the current status of FSEC growth.

Early in 1980, the ISMS Council on Medical Services began a review of free standing emergency centers (FSEC) and the issues surrounding such centers. As a result of this review the Board of Trustees adopted the following position in October of that year:

"(The Board of Trustees) supports the use of free-standing emergency rooms (FSECs) in a local mobile intensive care unit system when the project's medical director believes their utilization will increase the effectiveness of the system.

"A hospital-affiliated free-standing emergency room—governed by the same administration, trustees, and bylaws as its parent hospital, and sharing a common medical staff—should be considered under the hospital's license and subject to the same quality assurance and certificate-of-need regulations as the hospital."

In April 1981, the ISMS House of Delegates adopted Substitute Resolution 43 (A-81) which directed that a report on hospital satellite emergency centers in Illinois be developed for publication in the *Illinois Medical Journal*. An ad hoc committee of the Council on Medical Services was created to develop the report. This task also provided opportunity to supply information to the membership on alternative health care systems, an established goal of ISMS.

At the same time, the Illinois delegation to the AMA was directed to propose a resolution calling for the development of a national report on free standing emergency centers. The AMA House adopted the Illinois resolution and a commission was assigned to research the topic. However, the AMA study group has been cautioned by its legal counsel to avoid analysis of the "competition" between physicians and FSECs, due to potential restraint of trade implications.

What is a Free Standing Emergency Center (FSEC)?

A "free standing emergency center" is recognized as a facility physically separate from a hospital, rendering emergency medical services, and accepting patients on a non-appointment basis. Because many private physician offices, with expanded hours and services, could also be classified as meeting these criteria, the following definition was developed by the ISMS ad hoc committee to

describe FSECs in Illinois:

> "A free standing emergency center is a facility, physically separate from any licensed hospital building, which advertises in some way the availability of treatment for conditions considered by the medical profession or the lay public to be emergency in nature.
>
> "Such centers provide this treatment on an initial or interim basis by or under the supervision of a licensed physician to patients who present themselves to the center and require a critical or urgent response.
>
> "Such centers usually operate on a nonappointment basis for a predetermined number of hours daily, including times when care from other local facilities is not available.
>
> "The forms in which these centers exist vary, and include private (independent) and hospital affiliated centers. Facilities which provide services solely for enrollees under pre-payment plans (HMOs & IPAs) are not considered as part of this definition, though similarities may exist."

FSECs may be called by many names, such as: immediate or urgent care centers; emergicenters; ambutals; free standing emergency rooms; hospital satellite facilities and accident centers.

Ambulatory surgical centers may be confused with FSECs, since surgical centers may also be free standing or affiliated with a hospital. However, ambulatory surgical centers do not render emergency treatment to individuals on a non-appointment basis and generally perform only scheduled outpatient surgical procedures.

Growth of FSECs

Illinois, and the rest of the country, is experiencing the rapid development of three varieties of free standing emergency centers: hospital sponsored, corporation sponsored and private physician owned and operated centers.

In 1975, a national study of FSECs conducted by the Orkand Corporation identified 55 such facilities in the U.S. At that time, only one FSEC was known in Illinois, the Crystal Lake Ambutal, owned and operated by Sherman Hospital in Elgin.

Although an accurate count of FSECs is difficult, due to variances in ownership, operation and identification of services, a 1983 Orkand study, done in cooperation with the National Association of Freestanding Emergency Centers (NAFEC), identified over 500 centers in the country—with 1000 such facilities expected to serve some 12 million patients by the end of 1983. More than forty FSECs are known to be operating in Illinois and more are planned.

Issues Surrounding Development Of FSECs

The following issues are of concern to hospitals, hospital-based physicians, private practice physicians and FSEC owners alike:

Competitive Aspects—Private practice physicians are concerned about the competition from FSECs, which are seen as offering many of the same services as provided in a doctor's office. However, hospital-based physicians at an institution which owns an FSEC may support its development if the center generates patient referrals to medical staff members.

Proprietary and physician-owned centers are also concerned with hospital development of satellite emergency facilities. Hospital-owned FSECs are perceived to have an "unfair advantage," because of their not-for-profit status, which may be used to subsidize units which compete directly with them and with local physician offices. Hospital-affiliated centers are also known to receive better reimbursement from third-party payers.

Recently, private corporations, and in particular, proprietary hospital chains, have been active in creating FSECs. These firms have the option of developing FSECs which are officially sponsored by corporate-owned hospitals, or alternatively, may establish independent centers without hospital affiliation. In Illinois, one corporation has elected to utilize both methods for establishing FSECs.

Quality of Care—All of the above groups are concerned about the quality of care provided to patients at an FSEC. Most centers provide episodic care, with follow-up or continuity of care neither anticipated nor desired. However, several FSECs are now considering serving the full primary care needs of patients.

An important and controversial issue related to competition and quality of care concerns is the use of the term "emergency" in FSEC signs and advertising. Few of these facilities are staffed or equipped to handle life-threatening emergencies, and many centers publicly emphasize their intent to treat only "minor" emergencies. However, it has yet to be shown that the public can or will make the distinction between "minor" and "major" emergencies.

FSEC designation as the destination point for life-threatening cases has concerned physicians and FSEC supporters. One trade group, the National Association of Centers for Urgent Treatment (NACUT) has stated:

> "... The members of NACUT support preparedness for the initial stabilization and treatment of life-threatening medical problems, but are opposed to and discourage the solicitation

of these types of cases where it is contrary to sound medical care."

Regulation—Hospital development of FSECs is subject to Certificate of Need (CON) requirements. It is estimated that during the CON process a hospital will spend anywhere from $100,000-$200,000 in filing, architectural and engineering fees, analysis of hospital utilization rates and feasability studies prior to receiving a final review by the state regulatory authority.

Federal law was recently amended to raise CON thresholds from $150,000 to $695,000 for licensed health facilities and from $75,000 to $400,000 for major medical equipment. However, it is uncertain whether raising the thresholds requiring state approval will permit hospitals to avoid the CON process for development of free standing emergency centers.

FSECs which are independent or physician owned facilities are required simply to inform the state of their development plans if costs exceed the new CON thresholds. However, the state has no authority to prevent or modify development.

Free standing emergency centers in Illinois, regardless of their ownership, are currently considered to be in the same category as physician offices and, therefore, not subject to licensure requirements. The Illinois Department of Public Health, which regulates hospitals, has taken the position that a hospital-owned FSEC does not fall under that hospital's license if it is located off campus. Therefore, the FSEC does not have to meet state requirements for hospital emergency rooms.

Differences in Reimbursement—Hospital vs. Independent Centers—Hospital sponsored FSECs, by virtue of their direct affiliation, are eligible as "providers" of medical service by Medicare under Part A. "Providers," (defined as hospitals, skilled nursing facilities or home health agencies) are eligible for reimbursement of their costs related to physician services, nursing services, overhead, heat, light, and the administrative time of the physician on duty. Physicians providing medical service are paid under Part B.

Independent, physician and corporate owned FSECs are eligible to receive Medicare reimbursement under Part B only. Reimbursement is limited to physicians' and "incidental" costs. As a result, many independently owned centers do not accept Medicare or Medicaid assignments due to an inability to charge for their extra overhead costs.

Insurance carriers share Medicare's position, viewing non-hospital affiliated FSECs as physician offices. Many emergency services which are reimbursable by an insurer when completed in a hospital emergency room are not reimbursable when performed in a physician's office or independent FSEC, although it is generally recognized that comparable treatment performed in these facilities is less costly.

Illinois' Free Standing Emergency Centers

In early 1982, the Ad Hoc Committee on Free Standing Emergency Centers communicated by phone with known Illinois FSECs, both hospital affiliated and privately operated facilities which might be categorized as emergency centers. The study was to determine staffing practices, medical services available, hours of operation, reimbursement patterns and other pertinent information.

All centers were contacted by mail in advance to notify them that a phone survey would be conducted. All but two of the then existing centers participated in the survey by answering at least part of the questionnaire.

Number of Centers—Early in its deliberations, the ad hoc committee identified twenty-three FSECs in Illinois operating under various forms of ownership. Eight of the total were owned by hospitals, fourteen by a physician or physician group, and one center was corporate owned. Two centers were located in Peoria; the remainder were in northeastern Illinois. Most centers were located in middle to upper middle class suburbs.

Incentives for Operating FSECs—In order of frequency, the following responses were selected as reasons for establishing a center: (1) a desire to improve access to health care in the community; (2) an identification of the need in a geographic area for additional emergency and outpatient services; (3) an interest by hospitals to increase their patient base; (4) an interest in future hospital establishment or expansion of the FSEC to include outpatient and surgical treatment services; (5) community request for development of a free standing emergency facility and (6) development of a medical facility which would operate in the public interest. One incentive which was not on the survey but is an important one to add, is a desire to accumulate income. This was pointed out to us in subsequent correspondence with FSECs.

Affiliation Agreements—Most centers indicated they had provision for transfer of patients to area hospitals when necessary. Interestingly, hospital affiliated centers denied that, as a rule, they restricted patient admissions to their parent hospitals.

At the time of the survey, centers generally were not interested in providing ongoing primary care at their facilities and usually urged patients to contact their personal physician when follow-up care was required. If a patient indicated he did not have a personal physician, and it was estimated that about 60% of patients do not, the centers normally referred the patient to a private physician for

follow-up treatment as needed. In a hospital affiliated FSEC, the referral was directed to physicians with medical staff privileges at the sponsoring hospital.

Many FSECs have formal agreements for provision of care with ambulance services, local fire departments, and industry. Some centers also maintain informal agreements with HMOs and private physicians.

Not all physicians staffing FSECs have medical staff privileges at area hospitals. In some situations, local medical staffs have limited or prohibited hospital admitting privileges for full-time FSEC physicians, while in other instances these physicians have chosen to avoid hospital staff involvement.

Charges and Reimbursement Policies—Two independent centers indicated that they would not accept indigent patients for treatment, though the patient's medical condition would be taken under consideration.

The independent centers generally agreed that their charges were about equal to fees of private physicians, although less than fees charged by a hospital emergency room. Hospital sponsored centers indicated their fees were likely to be higher than those charged by private physicians.

Private centers requested direct payment for service, although most accepted all forms of third party payer reimbursements. The only restrictions indicated in the survey about third party payments included: (1) refusal or reluctance to accept Medicaid reimbursements and (2) requirements of some centers that patients pay for services and handle personal reimbursement with their medical insurer.

Procedures—Uniformly, the centers surveyed stated that patients requiring emergency treatment were always seen by physicians. Following discharge, the medical records are transferred to private physicians upon request of patients. Centers do not have provision for overnight stay of patients, but will transfer patients to hospitals for inpatient admission. Life-threatening emergencies were said to occur at the centers in less than 2% of the cases.

Hospital sponsored centers were found to operate twenty-four hours a day, seven days a week. At the time of the survey, the private centers identified did not operate beyond midnight.

Staffing—With respect to staffing, private independent centers normally have a minimum of one physician, one registered nurse and clerical personnel on duty. Hospital sponsored centers had similar staffing.

Official Positions of National Organizations

Many health related associations have been looking at the issues surrounding FSECs, although few have adopted an official policy recommending action.

The American College of Emergency Physicians (ACEP) has been the most vocal of all organizations, recommending specific standards for the operation of any facility rendering emergency services. Many state chapters of ACEP expressed concern about the quality of care available at free standing emergency centers, and adopted criteria in the interest of identifying factors which should provide a safe environment for treatment of medical emergencies. The Massachusetts Chapter of ACEP adopted the following position:

> "The presentations of various complaints are often determined to be non-life threatening through professional assessment. Yet many such presentations are similarly found to be early warnings of serious disease, often requiring early intervention. The public cannot be expected to differentiate, particularly in a moment of crisis, or be expected to seek or determine the most appropriate facility or method of accessing the health care system. The patient will seek any port in his storm of fear."

The American Medical Association has conducted a number of hearings on FSECs and has debated the adoption of "advisable criteria" for operation of centers which use the term "emergency" in advertisement of services. In June 1983, the AMA House of Delegates received a report listing specific criteria for centers providing full emergency services. The AMA report acknowledged that most FSECs will not meet the criteria, nor for that matter do these centers intend to meet the full emergency needs of the public.

At least two national organizations have formed to represent the interests of FSECs and to provide for self-regulation of their members. The major one is the National Association of Freestanding Emergency Centers (404 Bruton Park, 8700 Stemmons Fwy., Dallas TX 75247). NAFEC is a trade association, founded in 1981, with a membership of approximately 133 centers in 28 states, or 25% of the existing facilities.

Conclusions

The data compiled about FSECs by the ad hoc committee, and the comments and concerns received through its own deliberations and those expressed at the 1983 annual meeting of the ISMS House of Delegates, lead the committee to the following conclusions:

(1) More free standing emergency centers will be developed in Illinois in the near future. The

number of existing centers has doubled since this report was first initiated.

(2) It is anticipated that as the number of physicians increases there will be more interest in the salaried or franchised opportunities these centers offer. The development of FSECs may be considered one more step in the trend toward the corporate practice of medicine.

(3) Quality of care in free standing emergency centers will continue to require close scrutiny. There are many physicians who feel that standards and regulations should be developed for facilities which advertise or are classified as providing "emergency, urgent or accident care." But the problem of clearly separating where a physician's office ends and an emergency center begins will become more acute as physicians expand their activities in response to this competition.
Additionally, while several professional and trade organizations have developed quality of care criteria or guidelines, a single accepted set of standards will need to be created before the public and the medical profession can feel comfortable with the care provided in FSECs.

(4) A standard definition of "free standing emergency center" may be advisable. It should probably include quality of care considerations and address the problems inherent with the public's misinterpretation of a center's ability to handle life-threatening situations.

(5) Patients go to an FSEC for a variety of reasons, including the center's convenience, the lack of needing an appointment, the center's extensive advertising, the patient's perceived savings of medical costs and a general lack of understanding as to the level of services offered.

(6) Physicians who offer expanded hours and open appointment schedules could easily match the attractiveness of an FSEC at a lower cost to the patient.

(7) A physician may benefit or be hurt by the opening of a nearby FSEC. The impact depends upon whether, as a specialist, he/she receives referrals from the center, or, as a primary care physician, he/she loses routine care patients. The relationship between the physician and his/her patients is the major factor in whether patients will permanently leave the practice.
An FSEC could provide, by agreement, back-up care for a doctor's patients during the office's off-hours. Such an arrangement should preclude the ultimate loss of patients, since most FSECs disclaim any desire to provide follow-up care.

(8) To deal with the perceived "unfair competition" by hospitals, local physicians should take advantage of their opportunity to impact upon the development of hospital based facilities through interaction with hospital committees, the Illinois Department of Public Health's Health Facilities Planning Board and local health planning agencies.

Free standing emergency centers can and will impact upon private physician practices. It therefore behooves physicians to understand the appeal, opportunities and problems of this form of medical practice. Private practice physicians should become aware of their patients' needs and desires for after-hour medical care and, when necessary, adjust their method of practice to more fully accommodate their patients' needs.

ISMS will continue to bring information about development of free standing emergency centers in Illinois to the membership as part of its commitment to provide information on health care delivery systems.

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The Physician's Role in the '80s
Charting The Road Ahead

Talk to a physician who has practiced medicine for the past 15 years. Talk to someone who is known by neighbors to be a good doctor, a physician who spends time with patients, a physician who keeps on top of the latest medical advances.

He's likely to say he's "seen it all."

He'll probably tell you about the great technological leaps made in medicine during the 1960s. He might explain how society's perception of "physicians as supermen" zenithed in the early 1970s. He may even give you his views on the dark days of the malpractice crisis.

And he'll probably give you a warning: the profession is changing.

The medical field is different now—tougher. Years ago, all a physician had to know about was medicine. Today, he's got to be a jack-of-all-trades. He's got to know the ins and outs of a half-dozen other fields, too. He's got to be able to play the economics game, the legal game and the political game.

Treating patients remains his main concern. But now, a truly good physician has to know about more than just medicine if he plans to succeed.

Countless physicians in Illinois sense that the profession is changing. Some feel uncertain about the way the medical profession is transforming. Others feel downright threatened. All have questions.

November Conference Provides Some Answers

Recognizing these concerns, the Illinois State Medial Society will sponsor a weekend conference in November that will inform physicians about new reimbursement systems such as diagnosis related groups (DRGs), examine the "new malpractice crisis" and describe how physicians can contribute to the modifications being made in hospital medical staff structures.

The symposium is titled "The Physician's Role in the '80s—The Clinician as Economist, Negotiator, Legal Expert, Reviewer, Communicator and Political Organizer." The state medical society has selected a nationally recognized faculty of experts in medicine, law and economics to address the challenging new roles physicians face in the decade ahead.

The symposium will be held on November 12 and 13 at the Decatur Holiday Inn, Decatur, Illinois. Nine hours of category one continuing medical education credit are available to participants. Registration and hotel reservation materials can be obtained by completing the form in this issue (see page 215) or by contacting the director of ISMS meeting services at 312/782-1654. (55 E. Monroe, Suite 3510, Chicago, IL 60603.)

"Up until now, we've heard people speak in generalities about issues such as health care economics and professional liability," said ISMS President Dr. Robert P. Johnson. "What the ISMS symposium offers are specifics—what DRG implementation means to the physician and what constructive measures a physician can take personally to better the professional liability situation."

"The conference will give the physician an opportunity to learn what he will personally need to know to confront these dramatic changes taking place in our profession and serve as a knowledgeable resource to his peers," Dr. Johnson added.

Ramifications of Economic And Malpractice Issues

The morning session on Saturday, November 12 will feature two main dialogues. The first, "Economics of Health Care in the '80s," will be presented by Jeff Goldsmith, Ph.D., the guest speaker at the recent ISMS Conference on DRGs *(see box)*. Mr. Goldsmith's remarks will detail how economic aspects of health care delivery will affect health care quality, peer and utilization review and the malpractice situation.

The second morning portion will feature the "ISMS Professional Liability Initiative." Fred Z. White, M.D., Chillicothe, will be among members of a panel of physicians, attorneys and political pollsters who will discuss why physicians face a new malpractice crisis and potential strategies to produce a comprehensive legislative reform package.

Saturday afternoon will be divided into three break-out sessions. The first concerns health care delivery systems based on financing (such as DRGs, Preferred Provider Organizations, HMOs and IPAs). Procedures and regulations emanating from the mandatory reporting law are the focus of the second session. How the Hospital Revenue Act will affect hospital medical staffs and the financial standing of Illinois hospitals is the theme of the third, where Alfred J. Clement, M.D, Arlington Heights and State Senator Prescott E. Bloom (R-Peoria) are among scheduled speakers. U.S. House of Representatives Minority Leader Robert Michel (R-Peoria) is slated as guest speaker for dinner.

The Need for Political Action and Participation

The morning session on Sunday, November 13 is devoted to legislative matters—chiefly the Illinois State Medical Society Political Action Committee and individual physician participation in political activity. U.S. Representative Richard Durbin (D-Springfield, 20th Congressional District) will tell

DRG Conference Turnout and Recent Legislative Victories Signs Of Growing Physician Participation

As evidenced by the exceptional physician turnout at recent conferences on diagnosis related groups (DRGs) and the striking legislative victories claimed earlier this year, physicians are becoming increasingly politically astute and assertive.

More than 1,100 physicians attended three conferences sponsored in July by the state medical society on today's hot topic: DRGs. A short while before that, as the Illinois General Assembly was closing its spring session, physicians scored a major triumph in lobbying against and strongly defeating legislation designed to assess pre-judgment interest on malpractice awards.

"These actions indicate a rekindling of spirit on the part of physicians," said Dr. Robert P. Johnson, president of the Illinois State Medical Society. "They show physicians are ready to move, to take action, to promote what's best for ensuring the high quality of care our patients deserve."

The DRG conferences were aimed at explaining how a DRG-based system operates, how hospitals are likely to respond to DRG implementation and what physicians should be doing to prepare for the DRG start-up in October. Dr. Johnson headed the conference panel, which also featured the nationally-known health economics expert Jeff Goldsmith, Ph.D., ISMS and American Medical Association Trustee Dr. John Ring, chairman-elect of the Illinois Hospital Association Board of Trustees John King and ISMS director of health care finance, Robert Burger.

Response to the conferences was extremely positive.

"Physicians wanted and needed to know about DRGs," Dr. Johnson explained, adding that the topic also will be considered at the ISMS symposium in November.

During the seminars, Mr. Goldsmith reviewed the reasons why the DRG system was introduced, specifically citing the economic crisis in medicine. In speculating on the implications that the DRG system holds, Mr. Goldsmith predicted that physicians will face diminished economic and professional freedom as well as increased tension with hospital administrations.

After Mr. Burger explained the mechanics of a DRG system, Dr. Ring labeled the new system a "Dangerous Risky Gamble" and questioned the cost effectiveness and impact on quality health care delivery that DRGs will have. Mr. King noted that hospitals will be placing a greater priority on accurate record-keeping. He said that the new system "will place a premium on leadership in the hospital medical staff and hospital administration."

Mr. Burger urged physicians to take advantage of the many resources available in dealing with the new system. He advised physicians to consult state and county medical societies, professional review organizations and hospital medical staffs.

A videotape presentation of the conferences will be available in the near future. Also, physicians can obtain conference materials and an ISMS brochure titled "What Physicians Should Know About DRGs" by contacting Mr. Burger at 312/782-1654. ◀

physicians why they've been "legislatively successful" in the past—and what it will take to continue this success.

Sunday breakout sessions concentrate on malpractice/loss prevention matters and hospital medical staff organization. Donal D. O'Sullivan, M.D., J.D., ISMIS medical director, is one of the panelists on liability issues, which include the psychological trauma physicians face during malpractice situations and implementing the "3M" (mortality, morbidity, malpractice) approach to avoiding lawsuits. Dennis O'Leary, M.D., president of the District of Columbia Medical Society, will address the increasing importance of medical staffs and their relationships with hospital administrations and governing boards. J.M. Ingalls, M.D., Paris, will moderate and ISMS trustee John Ring, recently elected American Medical Association trustee, will share that platform.

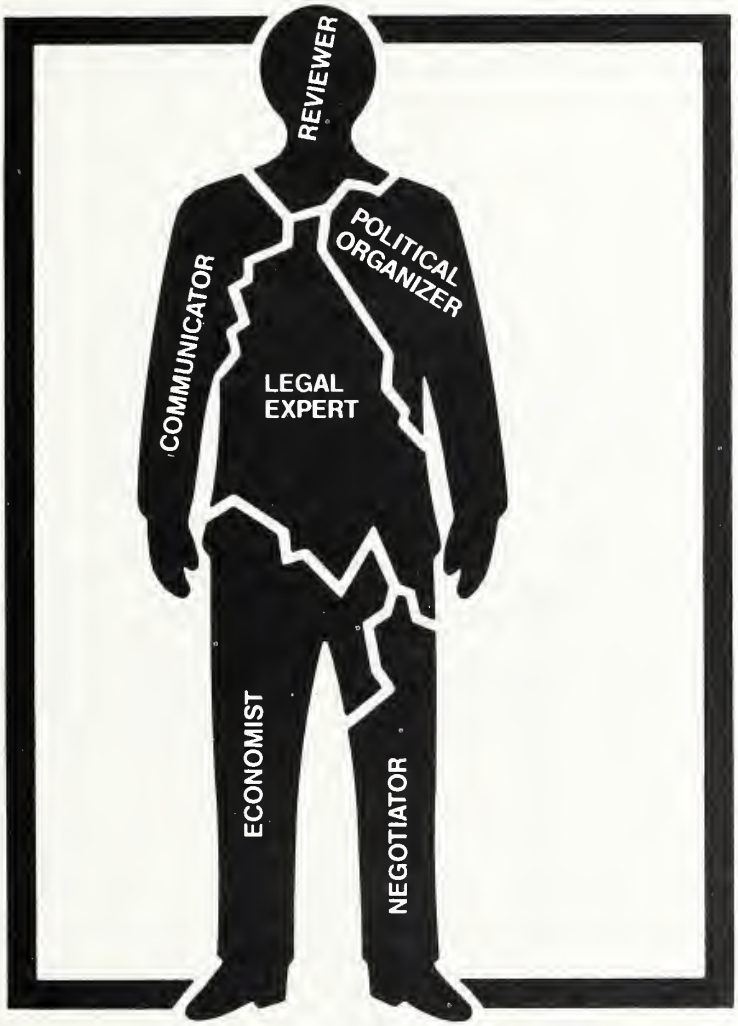
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Physicians know the importance of staying on top of issues and keeping abreast of changes; being up-to-date is essential to good medicine. Physicians are quite familiar with challenges. And physicians know the united strength they can muster.

"If physicians learn what changes are expected, they will be better prepared to serve their patients. It's as simple as that. A physician who is informed is a better all-around doctor," Dr. Johnson explained.

"This November symposium is for any physician who cares about the profession—who cares about the circumstances which influence the way we're allowed to treat our patients," Dr. Johnson said. "Given the array of informative, relevant and important symposia to be offered, I urge every physician to register and attend." ◀

THE PHYSICIAN'S ROLE IN THE '80s



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- **How hospital medical staff structures are changing—and what physicians can contribute in their evolution.**

NOVEMBER 12 AND 13, 1983

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FURTHER INFORMATION FORM

☐ I want to know more about this ISMS program. Within the next few weeks, please send me information that details the conference schedule, highlights the background of the conference speakers and explains how I register.

Name_____ Address_____

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To receive more information: complete, detach and return this form to the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, IL 60603

IMPAC

Illinois State Medical Society
Political Action Committee
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

Fighting Pre-judgment Interest...We'll have to do it again

The issue of prejudgment interest, which would have increased professional liability premiums, was defeated in 1983 through the efforts of ISMS members. While this is a victory we can be proud of, it does not mean that the issue is defeated forever. Like many issues, the sponsors can bring it back again and again. For this reason alone, we must retain and increase the number of legislators favorable to our position on this and other issues in the Illinois Senate and House of Representatives.

Legislative activity, funded through your ISMS dues dollars, is a very necessary activity to bring the ISMS message before elected officials. However, political activity is equally important because it helps elect fair and defeat unfair officeholders. Political activity may not legally be funded by ISMS dues, but depends upon the voluntary contributions of ISMS members each year. With the election year fast approaching, IMPAC is now making preparations for extensive involvement in the electoral process. I hope you will join other IMPAC members in this effort by contributing to IMPAC today.

Pre-judgment interest, and other such unfair legislation, would be much easier to defeat if candidates were elected who would at least listen to the physicians of Illinois. Your support for IMPAC and your local political activity can make this happen. Make your check in the amount of $45 payable to IMPAC and send it today to IMPAC, 55 East Monroe Street, Suite 3510, Chicago, Illinois 60603.

Sincerely,

C. C. Wiggishoff M.D.

Cyril C. Wiggishoff, M.D.

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

Doctor's News

PHYSICIANS IN THE NEWS—The June 29 installation of **Harry A. Springer, M.D.,** Evanston, as president of the Chicago Medical Society marks the first time that a physician/spouse team has held the offices of CMS and CMSA president concurrently.

Also named to CMS offices were: **Jere E. Freidheim, M.D.,** Burr Ridge, president-elect; **Richard H. Blankshain, M.D.,** Oak Park, re-elected secretary; **Joseph C. Sherrick, M.D.,** Northbrook, re-elected treasurer; **Harold L. Jensen, M.D.,** Flossmoor, chairman of the council; and **James H. Andersen, M.D.,** Oak Brook, vice-chairman of the council.

Lee B. Sacks, M.D., Des Plaines, was recently elected to the Illinois Academy of Family Physicians Board of Directors for a three-year term.

Richard A. Mintzer, M.D., Highland Park, will receive the honor of fellowhip in the American College of Radiology at the ACR annual meeting in Denver on September 27.

Juanito S. Barolome, M.D., F.A.C.S., Chicago, Southeastern branch and council member of the Chicago Medical Society, and ISMS delegate, was recently installed as president of the Illinois Philippine Medical Society for 1983-84. Other officers elected were: **Edmundo Relucio, M.D.,** Coal City, president-elect; **Julian Amado, M.D.,** Northbrook, vice-president; **Ramoncito Edrosa, M.D.,** Chicago, secretary and **Pascual Sales, M.D.,** Oak Lawn, treasurer.

WORKERS' COMPENSATION PROGRAM—The Dodson Insurance Group recently notified ISMS that a 44% cash dividend will be paid in 1983 to physicians insured in the Dodson Workers' Compensation Program. Checks and dividend credits were to be mailed on or about September 1.

FREE CONFERENCE OFFERED ON CLINICAL GERONTOLOGY—ISMS members are invited to attend an eight-hour full-day symposium on pragmatic clinical gerontology. The program is offered through the Illinois Masonic Medical Center.

Topics discussed in the symposium will include educating physicians and medical students in geriatric medicine, restorative activities of daily living, hospice care, tests for thyroid function and more.

Registration requests can be confirmed by writing: Dr. B. Moss, Medical Director, W.B.P., 66 W. Oak St., Chicago, IL 60610. Registrations will be accepted on a first-come first-served basis.

ALCOHOLISM GRANT AWARDED—Mercy Hospital and Medical Center, Chicago, recently received a $5,000 grant from Continental Illinois National Bank for the center's Alcoholism Treatment Unit. The funds will be used to produce training films for alcoholism counselors.

AAFP MEDICAL FORUM—"Family Practice, a Specialty for All Ages," will be the theme for the 35th Annual Convention and Scientific Assembly of the American Academy of Family Physicians (AAFP) October 10-13 at the Miami Beach Convention Center.

The program will offer 12 educational activities and more than 100 practical topics specifically designed to acquaint family physicians with the latest medical advances. Topics will include breast mass, fractures in children, care and conditioning of the athlete, fetal monitoring and aspects of aging. For further information contact the American Academy of Family Physicians, 1740 West 92nd St., Kansas City, MO 64114.

PRIMARY CARE UPDATE—Interstate Postgraduate Medical Association will hold its 68th Scientific Assembly at the Diplomat Resort, Hollywood, Florida, October 31 to November 3.

The program, a primary care update, will concentrate on the following six areas of medicine, with emphasis on the problems that the primary care physician meets in day-to-day-practice: cardiology, geriatrics, pulmonology, gastroenterology, endocrinology and rheumatology. Lectures, panels and informal group discussions will be conducted by a faculty of 42.

IPMA is ACCME accredited and those attending the 68th Scientific Assembly may be eligible for 24 hours of Category 1 and 4 hours of Category 5 credit toward the Physicians Recognition Award of the AMA. Also, the program is acceptable for 24 prescribed/4 elective hours by the American Academy of Family Physicians and 24 hours by the College of Family Physicians of Canada. Program and registration materials are available from IPMANA, P.O. Box 1109, Madison, WI 53701.

MEDICAL COMPLICATIONS OF PREGNANCY—Internists, obstetrician-gynecologists and family practitioners are invited to register for a postgraduate course in medical complications of pregnancy, at the Palmer House, Chicago, on Friday and Saturday, November 11 and 12.

The course, sponsored by the department of obstetrics and gynecology of Mount Sinai Hospital Medical Center of Chicago, will offer a comprehensive review in management of the patient with autoimmune, cardiac, endocrinologic, hematologic, hypertensive, infectious, neoplastic, pulmonary and renal diseases.

Fourteen hours of Category 1 CME credit will be available and ACOG credits have been applied for. Fees for the course are $195 for physicians and $125 for housestaff and nurses. For more information call Glory Ervin at (312) 542-2005 or write Medical Complications of Pregnancy, The Department of Obstetrics and Gynecology, Mount Sinai Hospital Medical Center, 1500 S. Fairfield Ave., Chicago, IL 60608.

USP BOOKS FOR THE HEALTH PROFESSIONAL AND PATIENT—The United States Pharmacopeia (USP) now publishes its USPDI (USP Dispensing Information) book in two volumes. Volume I, *Drug Information for the Health Care Provider,* contains drug monographs, which describe category of use, precautions, side effects, interactions, packaging, general dosing information, specific dosage forms, storage, and patient consultation guidelines for more than 4,500 drug dosage forms and brands.

Volume II, *Advice for the Patient,* provides information in layman's language on instructions in proper drug use and side effects, corresponding to the patient consultation guidelines in Volume I. The two volume set allows physicians to make available a reference for patients while keeping a volume for their own consultation. Photocopies of Volume II monographs can be given to patients as long as they are distributed without charge to the patient for whom the drug is prescribed.

USP publishes updates every two months on significant changes in existing USPDI monographs and to provide information on important new drugs. The USPDI is supplemented with special consumer publications designed for use in physicians' offices, nursing homes, hospitals and other health care facilities, as well as for home use.

To obtain price lists and to order USP publications write to: United States Pharmacopeia Convention, Inc., Order Processing Department 87, 12601 Twinbrook Parkway, Rockville, MD 20852.

NEW NAME FOR MEDICAL CENTER—The Suburban Medical Center, 1555 N. Barrington Road, Hoffman Estates, has changed its name to Humana Hospital-Hoffman Estates.

CAREGIVING PROFESSIONS NEWSLETTER AVAILABLE—To receive a complementary issue of, *Human Services News,* a quarterly publication focusing on such topics as personal loss, grief and grief therapy, as well as physical and emotional health, write to: Human Services News, Box 2423, Springfield, IL 62705. ◀

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Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR, M.D., CONTRIBUTING EDITORS

Carcinoma of the Lung

Surgical Grand Rounds are held weekly on Tuesday, 5:00 pm in the Offield Auditorium of the Passavant Pavilion of the Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 24, 1982.

Dr. Ron Edelson: A 65-year-old white man was admitted with a three month history of hemoptysis. This began with increased sputum production and occasional blood streaking. One week before admission, he produced approximately one teaspoonful of bright red blood when he coughed. The patient had recent fatigue, but denied chest pain, fever, sweating, weight loss or dyspnea. He had smoked two packs of cigarettes a day for 30 years but had quit 15 years ago. He drank two to four ounces of alcoholic beverages a day. In 1976, a routine chest Xray revealed a density in the right middle lobe which was thought to be scar. This was followed with frequent chest Xrays. In 1980, the radiologist suggested that a small nodule had appeared in the area of the old scar. Additional study was not undertaken at that time.

In 1971, a tumor which contained poorly differentiated squamous cell carcinoma had been removed from his left groin. Extensive work-up at that time, including an exploratory laparotomy, failed to detect a primary tumor. The patient had remained well until the present illness. Additional medical history revealed hypertension controlled with medication.

At the time of physical examination, he was a well-developed, well-nourished, white man without acute distress. Vital signs were stable and he was afebrile. Head and neck examination was unremarkable. Cervical adenopathy was absent. Pulmonary, cardiac, and abdominal examinations were unremarkable, as was the remainder of his physical examination. Admission laboratory data included a complete blood count with a hemoglobin of 13.9gm percent, WBC of 7,200mm^3, SMA-20 automated blood chemistry values, urinalysis, and ECG within normal limits. Pulmonary function tests were performed and revealed that forced vital capacity, FEV1 and maximum voluntary ventilation all exceeded 100% of the predicted value.

Radiology: The first film, from 1975, shows pleural thickening in the region of the horizontal fissure. Another film in 1976 again showed pleural thickening in this region. Real evidence of parenchymal scarring was absent. In 1977, however, in addition to pleural thickening, an additional density was present which was presumed to be parenchymal scarring without a distinct nodule. In 1981, a nodular homogenous density was superimposed on this scarring, both parenchymal and pleural. One year later, in 1981, a relatively large mass without apparent cavitation was superimposed on this fissure. This was confirmed on the lateral view. It was not clear whether this occupied a middle lobe, upper lobe, or some combination of the two. Computerized tomography confirmed presence of the mass and suggested some hilar adenopathy without mediastinal adenopathy.

Dr. Ron Edelson: As part of the initial work-up, bronchoscopy was performed and a small amount of blood was seen coming from the right middle lobe bronchus. An intrabronchial lesion was not seen. Transbronchial brushings were obtained for cytology and revealed poorly differentiated carcinoma, type unspecified. The patient was taken to the operating room and a right posterior lateral thora-

cotomy was performed. A firm mass, 5cm in diameter, was found in the medial portion of the right middle lobe, crossing the major and minor fissures. Hilar lymph nodes appeared normal. The patient was subjected to a right pneumonectomy. He tolerated the procedure well and was discharged from the hospital on his tenth postoperative day in good condition.

Dr. Donald R. Peven (Pathology): Slides taken from the inguinal lymph node in 1971 demonstrated some residual lymphoid tissue, replaced by poorly differentiated, hyperchromatic tumor cells, a typical poorly differentiated, non-keratinizing squamous cell carcinoma. It is also known as a transitional cell carcinoma because in the lower portion of the body this tumor is thought to arise from the transitional cells between the columnar cells of the rectal mucosa and the squamous cells of the anal mucosa. Tumors of similar appearance are seen in the nasopharynx, sometimes referred to as lymphoepitheliomas, although in reality they are poorly differentiated squamous cell carcinomas. This tumor does not have any relation to the transitional cell carcinomas that are seen in the bladder.

Examination of the lung tumor reveals dense fibrous tissue containing cells with hyperchromatic nuclei, arranged in single layers on the fibrous septae. This is the pattern of bronchioloalveolar carcinoma. Closer examination (Figure 1) shows cuboidal to low columnar cells growing in a single layer on the fibrovascular tissue that previously supported the alveolar lining cells. These cells are thought to be derived from the cells lining the terminal bronchioles. Peripheral "scar" adenocarcinomas often show the bronchioloalveolar pattern, as in this case. The tumor approaches the pleural surface closely but does not penetrate it. The bronchial resection margin and the hilar lymph nodes were free of tumor.

Dr. Robert Vanecko: Do you consider this to be a bronchioloalveolar carcinoma or a scar carcinoma?

Dr. Donald Peven: This has the characteristics of a bronchioloalveolar carcinoma. There may have been some scarring in the area before the tumor developed, and there is evidence on the Xrays that there was definite pleural thickening over the tumor. Most peripheral adenocarcinomas arise in pre-existing scars.

Dr. Robert Vanecko: Although we are not going to discuss scar carcinoma today, it is interesting to consider what the implications may be as far as prognosis goes. This does provide an opportunity to review our surgical approach to carcinoma of the lung. Beginning in the late 1950s, there was a great interest in superradical pneumonectomies as a possible cure for carcinoma of the lung. This failed to cure patients with advanced disease and appeared to be too much surgery for the patients with early stages of the disease. It became apparent that a much better approach to the disease might be possible with less extensive resections and lobectomies became popular. The trend today in surgical treatment of lung cancer is more conservative resection and preservation of functioning lung. In certain stages of the disease, wedge resections or segmental resections have been advocated. The important factor is determining what the cure rates of these various procedures are in relation to the stage of the lung cancer, at the time of treatment. Lung cancer has been staged, as have most other cancers, on the TNM Classification. However, this is not entirely adequate. The stage itself does not necessarily correlate with the results. Within certain stages, the subgroups of tumors may respond quite differently from one another.

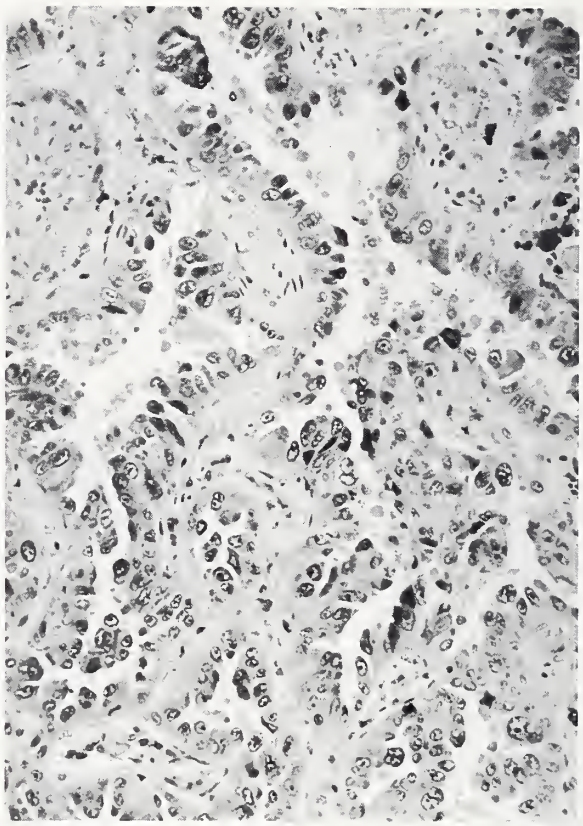


Figure 1
Bronchioloalveolar carcinoma cells growing along fibrovascular septae (H & E × 600).

Stages Identified

I would like to review briefly the classification of

Stage I lung cancer. The T_1 classification is namely based on size of less than 3cm. The N classification refers to the hilar lymph nodes. N_0 indicates absence of node metastasis. Stage I disease consists of relatively small peripheral lesions without nodal involvement (T_1N_0), small lesions with only the hilar nodes involved (T_1N_1) or larger lesions without nodal involvement (T_2N_0). Dr. Shields and his group, in the cooperative Veterans Administration study, have shown that within Stage I the survival rates for the T_1N_0 are considerably better than with the other two subgroups within Stage I, the larger lesion with negative nodes and the smaller lesion which has only hilar nodes involved. To make sense out of this when you are talking about lung cancer, T_1N_0 should probably be considered separately and these other categories (T_1N_1 and T_2N_0) should be considered as more advanced disease (Table 1).

Table I.
Survival After Resection For Lung Carcinoma

TN Classification	Survival 3 yr	4 yr	5 yr
T_1N_0	68.2%	59.3%	54.4%
T_2N_0	53.6%	44.6%	40.0%
T_1N_1	36.7%		
T_2N_1	39.8%	34.1%	

At Northwestern University, we are involved in a cooperative study with the National Institute of Health that involves several institutions across the country (including hospitals in Toronto, the Mayo Clinic, UCLA, and hospitals in the State of Washington) which is based on the TNM classification. These ongoing studies involve several stages of lung cancer and should lead to logical therapy for improved cure rates. With the T_1N_0 (the small peripheral lesion without nodal involvement) there is a study to evaluate these patients at the time of surgery. If it appears that the tumor could be treated by wedge or segmental resection, samples are taken of the hilar nodes, the subcarinal nodes and the mediastinal nodes. If these are all negative, then the patient is randomized to have either a limited resection (wedge or segmental resection) or a lobectomy. It is hoped that, with this prospective type of study, we may be able to determine that resections less than lobectomy are adequate for these early small carcinomas of the lung.

For the other two subgroups, in stage I, (lesions that are either over 3cm in size and the lymph nodes are negative T_2N_0 or that are small but have involvement of the hilar nodes T_1N_1) we are proposing that these patients be randomized and receive either no further treatment or four cycles of chemotherapy. It is hoped that this will show that this particular therapy is without value in these situations or that this particular form of chemotherapy will improve the survival in these relatively early lesions that have a poor outlook.

In patients with more advanced disease, Stage II and Stage III epidermoid carcinoma where there are no metastases, if the disease is confined to the hemithorax and can be completely resected surgically and if the margins of resection are free of tumor, we are attempting to randomize the patients into a group which receives no further treatment and a group which receives radiotherapy. Under the same circumstances, Stage II or Stage III, but with a histologic pattern of adenocarcinoma or large cell, the patients are being randomized into two treatment protocols. They will have treatment with triple drug chemotherapy or with immunotherapy which consists of stimulation of the immune system with BCG. It is again hoped that one of these two avenues will give some indication as to which might give better results in a particular group of patients who have a very poor prognosis. This could then lead to further applications in the field of chemotherapy or immunotherapy.

Finally another protocol is planned for those patients who have Stage II or Stage III disease without metastases, where the disease appears to be confined to the hemithorax, in whom resection is carried out, but where either gross tumor is left behind or at the time of pathological study, tumor is found at the edge of resections. These patients are placed on a randomized protocol for either radiotherapy or radiotherapy plus chemotherapy. It is hoped that through these studies, we will be able to determine if any of these treatments are effective and if they should be pursued further. We hope that the studies will improve the results, which are quite dismal overall for cancers of the lung.

Dr. John M. Beal: In this particular patient, who had had a malignant lesion in the groin nodes, was there any relation to the lung lesion?

Dr. Robert Vanecko: No, they were of two different tissue types. ◀

References

1. Shields, T.W., Humphrey, E.W., Matthews, M., Eastridge, C.E., Keehn, R.J.: "Pathological Stage Grouping of Patients with Resected Carcinoma of the Lung". *J. Thor. and Cardiovasc. Surg.* 80:400-405, 1980.

For further reading on this topic, please consult the authors.

Rheumatology Rounds

L. F. Layfer, Contributing Editor

Spondyloarthropathies III

Reiter's Syndrome

This is the third of three parts in the Rheumatology Rounds *series on spondyloarthropathies. Part I, featuring ankylosing spondylitis, was published in the September, 1982, issue. Part II, on psoriatic arthritis, was published in the February, 1983, issue. The editor welcomes your inquiries and comments.*

A 31-year-old male was seen for foot pain. Two weeks earlier he had noted some mild burning on urination without penile discharge. Three days after that, he began to have pain over the dorsum of his right foot, which was rapidly followed by right heel pain and tenderness of the first two metatarsal-phalangeal joints in the same foot. It was painful to walk and difficult to wear his shoe. Left elbow stiffness was noted soon after that.

He denied low back pain, eye irritation, venereal disease, bowel dysfunction, oral or penile ulceration and psoriasis or other chronic rash. He was on no medication and had no allergies. There was no family history of arthritis.

On examination he was afebrile. Vital signs were normal. Skin and nails were without lesions. A 2X2cm superficial erosion was noted on the hard palate. Examination of the eyes revealed mild erythema about the conjunctiva without exudate. Joint examination revealed a right heel tender on the plantar surface and a tender and somewhat swollen right foot dorsum. Several metatarsal heads on that foot were tender to palpation. The ankle and the Achilles tendon were without evidence of disease. The left elbow revealed some mild swelling and slight loss of extension.

Laboratory

CBC, platelets, SMA-18, and chest X-ray were all normal. Rheumatoid factor and antinuclear antibody were not present and complement levels were normal. Urinalysis revealed 7-10 WBCs without bacteria. Urine culture was sterile and urethral culture for gonococcus was negative. X-ray of the right foot revealed soft tissue swelling about the dorsum of the foot but was otherwise unremarkable. Testing for the HLA-B27 gene revealed it to be present.

Discussion

Although classically defined by arthritis, conjunctivitis, and urethritis, Reiter's syndrome is better considered an episodic systemic rheumatic illness involving multiple organ systems. Episodes often seem precipitated by sexually transmitted urethritis, (sexually acquired reactive arthritis-SARA) but dysenteric onset may occur and leads to a clinically indistinguishable syndrome. Some epi-

sodes, especially recurrences, are not heralded by a clear "trigger." Despite its initially episodic nature, Reiter's often evolves into chronic disease and disability.

Arthritis is the most constant manifestation of illness, occurring in over 90% of patients. Usually asymmetric and inflammatory in nature, it tends to select large joints of the lower extremity. Small joints of hands and feet are less often involved, but soft tissues such as plantar fascia or Achilles tendon are a common site of inflammation and often lead to heel pain. A characteristic calcification may be seen on X-ray near this area, resembling a heel spur. Sacro-iliac joint inflammation with variable ascension to the lumbar or cervical-thoracic spine leads to back pain in more than 70% of the patients. Often chronic despite remissions of other symptoms, it resembles the other spondyloarthropathies we have discussed in this series.

Urethritis, the next most common sign of illness, often is the initial symptom. Burning, and a discharge varying from mucoid to purulent, are often present. Other GU sites such as prostate or bladder, or in females, cervix, may be involved. No clear cause for either GU inflammation or "triggering" of the whole syndrome has been found. Organisms such as gonococcus, Chlamydia, or mycoplasma have been implicated, but treatment of these does not prevent or abate attacks and moreover, GU inflammation has been noted with dysenteric onset, suggesting it may be an end organ for the inflammatory disease rather than a "trigger" site. Conjunctivitis is the common eye symptom of Reiter's, with mild erythema or irritation. Deeper layers of the eye, such as the uveal tract or anterior chamber, may be involved. In rare cases, optic neuritis or intraocular hemorrhages have been noted and must be considered. Cutaneous disease presents often as a scaling, hyperkeratotic rash on the feet, or more rarely, hands or trunk (keratoderma blennorrhagica), where it is often mistaken for dermatophytosis or psoriasis. Onycholysis may also occur, further resembling psoriasis. Penile lesions consisting of small vesicles which open and coalesce to form shallow, painless ulcers in a circumferential pattern (circinate balanitis) also occur, as do superficial erosions in the oral cavity. More rarely, cardiac (EKG changes, conduction defects, pericarditis, arrhythmias), pulmonary (pleuritis), or neural (peripheral or cranial neuropathies) symptoms are noted. Diarrhea, due to Salmonella, Shigella or Yersinia, often seem to trigger onset of Reiter's. Diarrhea is the most common presenting symptom in women. Chronic bowel inflammation, like ulcerative colitis or regional enteritis, are not noted.

Reiter's is episodic, lasting from weeks to months, and is often associated with severe constitutional symptoms, including fever, malaise and weight loss. Relapses are common, occurring in 75% of cases, and chronic joint disease of spine or peripheral joints may develop. Differential diagnosis includes gonococcal arthritis, (especially when acute asymmetric arthritis occurs with urethritis) Bechets, (when oral ulcers, eye inflammation and joint and skin disease occur episodically) and psoriasis, (with skin, nail, and asymmetric joint changes). There are no definitively diagnostic tests: synovial fluid is nonspecific and auto-antibody tests are negative. X-rays are similar to other inflammatory spondyloarthropathies. HLA-B27, present in over 90% of whites with Reiter's and less so in blacks and other races, does not confirm the diagnosis but merely indicates a genetic predisposition. Diagnosis, therefore, is by typical clinical presentation and by appropriate exclusion.

Therapy is organ system specific. Peripheral or spinal joint inflammation may respond to a nonsteroidal anti-inflammatory agent such as indomethacin. Nonsteroidal anti-inflammatories are the mainstay of therapy. Systemic corticosteroid should be reserved for life threatening illness or severe constitutional symptoms, although local cortisone injections may be useful. Eye complications require the care of a skilled ophthalmologist and referral should be made. The nongonoccocal genitourinary symptoms have not been shown to respond to antibiotics, but tetracyclines are often tried for a 10 day course and are sometimes helpful.

Conclusion

The asymmetric peripheral lower extremity arthritis associated with heel pain, urethritis, conjunctivitis and painless oral ulceration suggested Reiter's syndrome in this 31-year-old male. The HLA-B27 positivity confirms genetic predisposition to this condition. Ophthalmologic consultation confirmed the conjunctivitis but revealed no deeper eye inflammation. He was begun on indomethacin 50mg q.i.d. with some moderate early relief and abatement of symptoms entirely within eight weeks. Medication was discontinued one month after that and he has remained asymptomatic for the last four months. His urethritis, initially treated with tetracycline 250mg q.i.d. for 10 days, recurred once since the initial episode. It was not followed by a recurrence of illness, was again culture negative for gonococcus and was subsequently treated with tetracycline in a similar dose with good resolution of symptoms. ◀

Bibliography

Selected bibliography on Reiter's syndrome is available on request through the editor.

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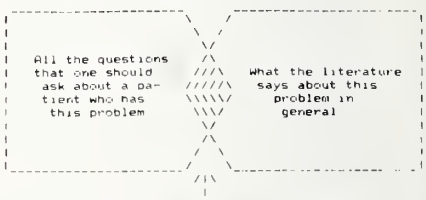
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(Continued from page 170)

Diagnosis: Primary Megaureter

All of the choices given can cause ureteral dilation without a mechanical obstruction. Vesicoureteral reflux would be a good possibility. The tapered appearance of the ureter and normal cystoscopy are against the diagnosis, but an examination to exclude reflux (cystogram or radionuclide cystogram) would be needed to exclude this possibility.

Diabetes insipidus results in large urine volumes and dilation of *both* collecting systems. Urinary tract infection can cause unilateral dilation but this patient had no indication of such an infection. Peritonitis can cause dilation which can mimic obstructed ureters but would be bilateral. In addition, this boy was not ill.

The segmental dilation of the distal ureter tapering smoothly to its junction with the bladder is highly suggestive of primary megaureter, especially since retrograde pyelography has excluded a distal obstructing lesion.

Primary Megaureter

The most common cause of a widened ureter is obstruction by a ureteral stone. There are, however, a wide variety of causes of a widened ureter (Table 1). In addition, it should be remembered that a widened ureter may not be obstructed. If there is a question concerning the presence or degree of obstruction when a patent ureter is dilated or hydronephrosis is present, specific tests can be

Table 1
Megaureter—Causes of Ureteral Widening

Nonobstructive

- Vesicoureteral reflux
- Urinary tract infection
- Peritonitis
- Diabetes insipidus
- Congenital absence of abdominal musculature

Obstructive

Lumen
- Stone
- Blood clot
- Necrotic papilla

Intrinsic—Ureteral Wall
- Stricture
  - Congenital
  - After instrumentation
  - After passage of stone
  - Tuberculosis, schistosomiasis, syphilis
  - Radiation
  - Methysergide
- Ureterocele
- Bladder (Hutch) diverticulum
- Congenital ureteral valve
- Primary or secondary malignancy
- Polyp
- Primary (aperistaltic) megaureter

Extrinsic
- Pelvic neoplasm or abscess
- Hematoma, urinoma, lymphocele
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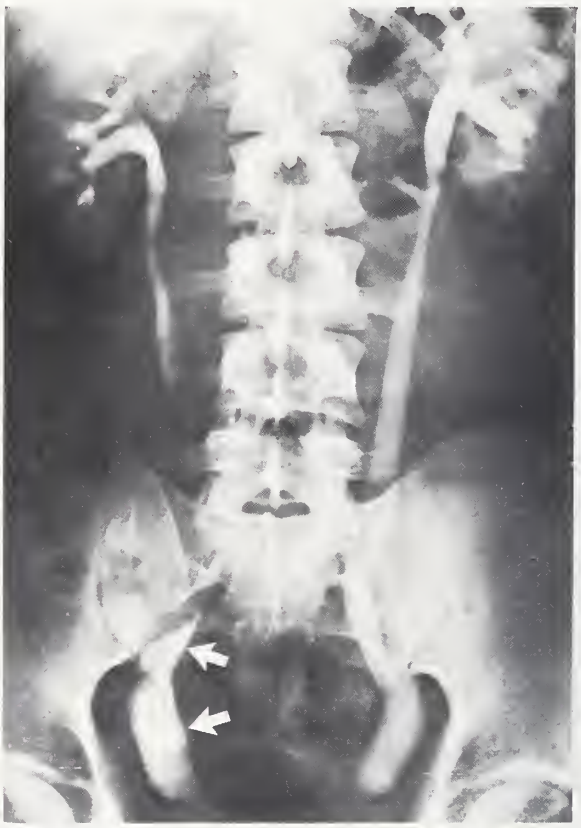


Figure 2
This 25-year-old-man has dilation of the distal right ureter (arrows) and the entire left ureter. This has been stable for at least five years.



Figure 3
This 60-year-old man has a stone in the renal pelvis. There is marked ureterectasis. Note the widened distal ureter tapering to a point at the ureterovesical junction on this retrograde pyelogram.

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Figure 4A



Figure 4B

Figure 4

(A) Severe bilateral hydronephrosis. (B) Retrograde pyelography shows markedly dilated distal ureters with injected left ureter tapering to a point at the ureterovesical junction (arrow). This patient was treated by ureteral reconstruction with dramatic improvement. *(Courtesy of Dr. James L. Brown)*

obtained. The diuretic Tc-99m DTPA renogram determines the presence of obstruction by measuring washout of isotope activity from the upper collecting system before and after administration of a diuretic, while the more definitive but invasive Whitaker test measures the pressure needed to force fluid through the system. The fluid is infused into the renal pelvis following percutaneous placement of a nephrostomy tube.

Primary megaureter refers to a congenital abnormality in which the distal ureter does not transmit a normal peristaltic wave. A functional rather than an anatomic obstruction is produced and results in variable dilation of the proximal collecting system. The etiology of this condition is poorly understood, but it is probably related to disorganized or deficient longitudinal muscle of the distal ureteral segment, which often contains increased collagen material.[1,2]

The diagnosis of primary megaureter is one of exclusion.[3] Obstructive megaureter due to distal intrinsic or extrinsic anatomic ureteral narrowing and ureteral dilation due to reflux through an incompetent ureterovesical junction must be excluded by cystography and retrograde pyelography. Classically, the narrow distal ureteral segment in primary megaureter averages 1.5cm in length, and the ureteral orifice easily admits a catheter of size appropriate for the patient's age.

Primary megaureter may be unilateral or bilateral (Figures 1-4). Up to 85% have been reported to be unilateral.[1] Other abnormalities of the urogenital system may be seen in up to 40% of these patients, the most common being ureteropelvic junction obstruction.[3] Patients may present with recurrent flank pain, hematuria, or repeated urinary tract infections.[4] The disease may be found in children, and a case of primary megaureter has been detected on a screening prenatal ultrasound examination at 31 weeks gestation and later confirmed by cystography and retrograde pyelography.[2] It is of interest that primary megaureter has been found in association with congenital megacalyces.[5] Congenital megacalyces are large but not obstructed. The renal cortex appears narrow in these patients but it is actually normal while the renal medulla is narrow. Renal function is not affected.[6]

The severity of primary megaureter is graded by the extent of proximal dilatation. In the mildest form, there is slight dilatation limited to the ureter just proximal to the narrowed segment (Figure 1). In the severest cases, there is uniform dilation of the entire ureter, hydronephrosis and obstructive atrophy of the kidney (Figure 4). Treatment depends on severity. Mild cases can be treated conservatively but patients should be followed since progression may occur and is variable and unpredictable. In complicated cases with parenchymal damage, recurrent infection, stones (Figure 3) or chronic pain, reconstructive surgery should be considered. ◀

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Psycho-Pharmacalagy
For: MD's. Lecture, Oct. 19, 1:00 p.m., Sheraton Hotel, Naperville. Sponsor: DuPage County Medicol Society, B00 Roosevelt Rd., Bldg. B, Glen Ellyn 60137. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours; AAFP Elective, 2 hours. **Contact:** Lillion Widmer. **Phone:** 312/858-9603.

Cordiology

Doppler and Two-Dimensionol Echacardiogrophy Workshop
For: MD's. Lectures/workshop, Oct. 17-20, Chicago. **Sponsor:** Northwestern University Medicol School/Northwestern Memoriol Hospital, 250 E. Superior, Rm. 586, Chicago 60611. **Reg. deodline:** 10/3. **Fee:** $350. **Reg. limit:** 180. **Credit:** Category 1, 23 hours. **Contact:** Sharon Joseph. **Phone:** 312/649-4687.

Cardiopulmonory Medicine

Scientific Assembly
For: MD's. Conference, Oct. 23-27, Hyott Regency Hotel/Illinois Center, Chicago. **Sponsor:** Americon College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deodline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30+. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

Criticol Core

Criticol Core Medicine
For: Anesthesiologists, Internists, Pediotricions, Surgeons. Lecture, Oct. 24-28, Chicago. **Speaker:** Dhormopuri Vidyosogor, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Credit:** Category 1, 40 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Emergency Medicine

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Internol Medicine

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For: MD's, Surgeons. Symposium, Oct. 11, 7:00 p.m., Vondolio. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

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Proctical Monogement of the Inflammotory Bowel Diseases
For: MD's. Symposium, Oct. 14, St. Louis, MO. **Spansor:** Woshington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $75. **Credit:** AMA Category 1, 9 hours; AAFP Prescribed, 9 hours; AOA, 9 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/454-3873.

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Chest Pain Syndromes
For: Internists. Symposium, Oct. 20-22, Chicago. **Spansar:** Center for Poin Studies, Rehobilitotion Institute of Chicago; Northwestern University Medicol School, 345 E. Superior, Chicogo 60611. **Fee:** $240; $150, residents. **Reg. limit:** 250. **Credit:** Category 1, 17 hours. **Contact:** Elly Henig. **Phane:** 312/649-6190.

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For: MD's. Symposium, Oct. 29, St. Louis, MO. **Spansor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $60. **Reg. limit:** none. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours. AOA, 6 hours. **Contact:** Loretto Giocoletto. **Phane:** 314/454-3873.

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Rodiology

Low Back Poin: Diognasis & Treatment
For: MD's. Symposium, Oct. 1, Chicogo. **Sponsor:** Gront Hospitol, 550 W. Webster St., Chicogo 60614. **Reg. deodline:** none. **Fee:** $35; $45, at door. **Credit:** Category 1, 6 hours. **Contact:** J. Melomed, MD. **Phone:** 312/883-2428.

Sports Medicine

New Concepts in Wrestling Weight Monagement
For: GP's, FP's, Internists. Seminor, Oct. 28-29, Urbona. **Spansor:** Carle Foundation Hospital 602 W. University, Urbono 61801. Reg. deodline: Oct. 21. **Fee:** $35. **Credit:** Category 1, 5 hours; AAFP Elective, 5 hours. **Contact:** Deborah Rugg. **Phane:** 217/337-3022.

NOVEMBER

Cordiology

Congestive Myocordiopothy
For: GP's, FP's. Seminor, Nov. 10, 2:00 p.m., Urbono. **Sponsor:** Corle Foundotion Hospitol, 602 West University Ave., Urbono 61801. **Reg. deadline.** 11/3. **Fee:** $35. **Credit:** Cotegory 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Deborah Rugg. **Phone:** 217/337-3022.

Cordiology

Current Cordiology
For: Internists, FP's, GP's. Lecture, Nov. 28-Dec. 1, Chicogo. **Speaker:** Stuort Rich, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $310. **Reg. limit:** 90. **Credit:** Cotegory 1, 22 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Chemicol Dependence

Office & Hospital Treatment of Chemical Dependence
For: Psychiotrists, Internists, GP's, FP's. Lecture, Nov. 7-9, Chicogo. **Speaker:** Froncois Alouf, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicago 60612. Fee: $280. **Reg. limit:** 55. **Credit:** Cotegory 1, 20 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Internol Medicine

Advonces in Internol Medicine
For: Internists. Lecture, Nov. 14-18, Chicago. **Speaker:** Sheldon Woldstein, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $390. **Reg. limit:** 90. **Credit:** Category 1, 35 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Medicine

Antibiotic Usage
For: Surgeons, FP's. Symposium, Nov. 8, 7:00 p.m., Effinghom. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Cotegory 1, 3 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Poin

Management of Poin
For: MD's. Symposium, Nov. 3, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Cotegory 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217/782-7711.

Poin

Pain Conference
For: MD's. Symposium, Nov. 18-19, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed; AOA. **Contact:** Soroh Aslokson. **Phone:** 608/263-2856.

Pothology

Urologic Pothology & Radiology
For: Urologists, Pothologists, Radiologists. Lecture, Nov. 28-Dec. 2, Chicogo. **Speoker:** Thomos John, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Reg. limit:** 55. **Credit:** Category 1, 40 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Pothology

Visiting Clinicion in Surgicol Pathology
For: Pothologists. Course, one or two weeks (year-round), Chicago. **Sponsor:** The University of Chicogo, 950 E. 59th St., Box 139, Chicogo 60637. Fee: $440/wk. **Credit:** Category 1, 40 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Pothology

The AIDS Problem
For: Pothologists. Lecture, Nov. 14, 7:00 p.m., The Droke Hotel, Chicogo. **Sponsor:** Chicogo Pothology Society, c/o Morsholl Short, MD, Loretto Hospitol, 645 S. Centrol Ave., Chicogo 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Morsholl Short, MD. **Phone:** 312/626-4300 X 5720.

Pothology

Surgicol Pothology of the Lung and Reloted Lesions of the Mediostinum
For: Pothologists. Course, Nov. 14-17, Chicogo. **Sponsor:** American Society of Clinicol Pothologists, 2100 W. Harrison St., Chicogo 60612. **Fee:** $500, members; $600, non-members. **Reg. limit:** 60. **Credit:** Category 1, 24 hours. **Contact:** Borb Agustin. **Phone:** 312/738-1336 X 188.

Plostic Surgery

Monogement of Upper Extremity Injuries
For: MD's. Symposium, Nov. 12, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. limit:** 150. **Credit:** Cotegory 1, 6 hours; AAFP Prescribed, 6 hours. **Contact:** Loretto Giocoletto. **Phone:** 314/367-9673.

Respirotory

Respiratory Criticol Core Symposium
For: MD's. Symposium, Nov. 3-4, Modison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $210; $125, resident. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed; AOA. **Contact:** Soroh Aslokson. **Phone:** 608/263-2856.

Surgery

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, Nov. 14-16, Chicogo. **Speaker:** C. Thomos Bombeck, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Reg. limit:** 15. **Credit:** Cotegory 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Flexible Fiberoptic Sigmoidoscopy
For: Abdominol Surgeons, Internists, Gastroenterologists. Lecture, Nov. 19, Chicogo. **Speaker:** Herond Abcarion, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $125. **Reg. limit:** 60. **Credit:** Cotegory 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

DECEMBER

Clinical Medicine

Computers ond Clinical Medicine
For: MD's. Symposium, Dec. 1, 1:00 p.m., Sparto. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contoct:** Lorroine Stephenson. **Phone:** 217/782-7711.

Neurology

Clinicol Neuroimmunology
For: Neurologists, Psychiatrists, Immunologists. Course, Dec. 7-9, Chicogo. **Sponsor:** University of Chicogo, 950 E. 59th St., Box 139, Chicogo 60637. **Fee:** NA. **Reg. limit:** none. **Credit:** Cotegory 1, 18 hours. **Contoct:** Mary Ann Dillon. **Phone:** 312/962-1056.

Neurology

Neurology for the Non-Neurologist
For: Internists, FP's, GP's, Psychiatrists, Rehab. Medicine. Course Review, Dec. 7-9, Chicago. **Sponsor:** Rush University, CME, 600 S. Poulino, Chicogo 60612. **Fee:** $350. **Reg. limit:** none. **Credit:** Cotegory 1, 20 hours; AAFP opplied for. **Contact:** Borbaro Trejo. **Phone:** 312/942-7095.

Ob-Gyn

Problem Solving in Gynecologic Endocrinology and Infertility
For: MD's. Course, Dec. 9-10, Chicogo. **Sponsor:** University of Chicago, CME, 950 E. 59th St., Box 139, Chicogo 60637. **Fee:** $195. **Reg. limit:** none. **Credit:** Cotegory 1, 11 hours; ACOG, 11 cognotes. **Contact:** Mory Ann Dillon. **Phone:** 312/962-1056.

Ob/Gyn

Outpotient Gynecology
For: GP's, FP's. Seminor, Dec. 3, a.m., Urbono. Sponsor: Corle Foundation Hospitol, 602 W. University, Urbono 61801. **Reg. deadline:** 11/25. **Fee:** $35. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contoct:** Deborah Rugg. **Phone:** 217/337-3022.

Rodiology

Visiting Fellowships in Diognostic Rodiology
For: Rodiologists. Course, one or two weeks (yeor-round), Chicogo. **Sponsor:** University of Chicogo, 950 E. 59th St., Box 139, Chicogo 60637. **Fee:** $450 per week. **Credit:** Category 1, 40 hours. **Contoct:** Mory Ann Dillon. **Phone:** 312/962-1056.

Gerontology

Progmotic Clinicol Gerontology
For: MD's. Symposium, Dec. 7, Chicogo. **Sponsor:** IMMG-Worren Borr Povilion of Illinois Mosonic Medicol Center, 66 W. Ook St., Chicogo 60626. **Reg. deadline:** Nov. 1. **Fee:** none. **Reg. limit:** 100. **Credit:** Category 1, 8 hours; AAFP Prescribed, 8 hours. **Contoct:** Bertram Moss, MD. **Phone.** 312/337-5400 X 268.

Heort Diseose

Diognosis & Monogement of Myocordiol Infarction
For: MD's. Symposium, Dec. 9-10, Modison, WI. **Sponsor:** U of Wisconsin—Extension, CME, 465b WARF Bldg., 610 Walnut St., Modison, WI 53705. **Fee:** $160. **Reg. limit:** none. **Credit:** Cotegory 1, 10 hours; AAFP Prescribed, 9½, opplied for: AOA, 10 hours. **Contoct:** Sorah Aslokson. **Phone:** 608/263-2856.

Medicine

Environmentol Medicine
For: Internists, GP's, FP's. Lecture, Dec. 5-9, Chicogo. **Speokers:** Stephen Greenberg, PhD; Emerson Doy, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $370. **Reg. limit:** 90. **Credit:** Cotegory 1, 30 hours. **Contact:** Robert 8oker, MD. **Phone:** 312/733-2800.

Thorocic Surgery

Specialty Review in Thoracic Surgery
For: Surgeons. Lecture, Dec. 5-10, Chicogo. **Speoker:** Sidney Levitsky, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $510. **Reg. limit:** 20. **Credit:** Cotegory 1, 48 hours. **Contoct:** Robert 8oker, MD. **Phone:** 312/733-2800.

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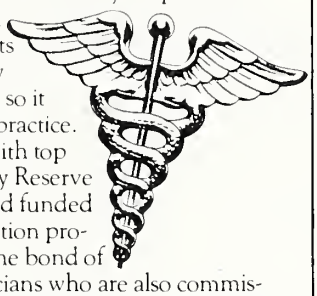
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President's Page

The above acronym, HPA, which you will hear of from time to time during the next couple of years, was a project conceived by the AMA Board of Trustees in early 1982 as a private and public health sector effort to develop a long-term, consistent approach to the health care issues facing the nation. The HPA is envisioned as a broad-based outline of the major health concerns for the foreseeable future and a coherent plan for responding to them.

———AMA brochure describing the history and purpose of the Health Policy Agenda.



HPA = HEALTH POLICY AGENDA
For the American People

As part of the HPA project, an advisory committee has been developed which encompasses representatives from many participating organizations in its membership. As the president of your state medical society, I am representing you in this capacity and am joined by other practicing physicians, nurses, dentists, hospitals, third-party payors, state and federal government personnel, medical schools, medical students, resident physicians, specialty societies, pharmacists, osteopaths, business, labor and many other health care groups and professionals. The initial meeting of this committee was held in late August and the committee acted upon its charge to review the work groups' development of basic principles that will help set the Health Policy Agenda for the United States.

Six multi-disciplinary work groups have been meeting during the past year to develop a set of principles in designated areas. These areas are: (1) medical science; (2) education; (3) health resources; (4) delivery mechanisms; (5) evaluation, assessment and control and (6) payment of services. The principles developed by the work groups were reviewed by the advisory committee. They will be revised by the work group in accord with testimony from members of the advisory committee and will be submitted to the steering committee for completion of editorial review. The organizations involved will then have an opportunity to review the principles and make a final determination about their appropriateness for their individual organizations.

The active participation of representatives from the organizations of the advisory committee during the hearings was most gratifying. This process should yield a concensus of opinion regarding basic principles. Those principles will be the foundation for establishment of long-range policies to be followed by the organizations involved with delivery of health care to the citizens of the United States.

The Illinois State Medical Society will have continuing input into this process through our representation on the work groups and the advisory committee. As phase one of the effort is completed the recommended principles will be appropriately reviewed by our councils, committees and boards.

I report this to you at this time to keep you updated on the continuing efforts of your organizations of medicine to bring together as many as possible of the concerned parties in an effort to place before the American people a health policy that will have a common framework and a starting point for their policy-planning activities. ◀

Robert P. Johnson, M.D.

Robert P. Johnson, M.D., President

JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

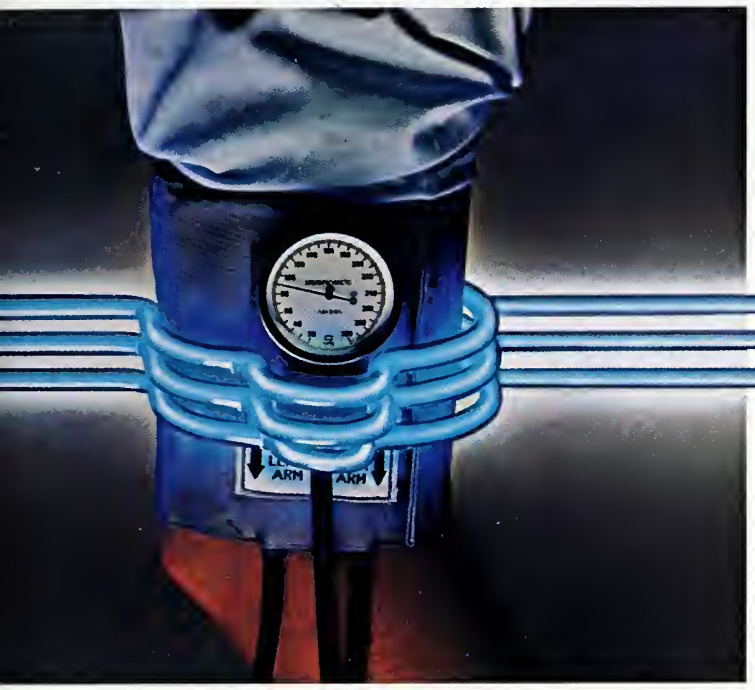
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



THE ONE™ TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

Ayerst®

The one to count on for HYPERTENSION, ANGINA and prevention of MIGRAINE.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

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Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8688/883

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Editorial

A Common Ground

Diagnosis Related Groups.

Egerton Yorrick Davis.

Down Syndrome.

"The Ultimate Decision."

At first glance, DRGs, a folk-hero physician, genetic disorders and restricted availability of medical services have little in common. What they do share is a common forum—the *Illinois Medical Journal.* The subjects I've listed here have been among the many wide-ranging pieces published in the last few issues.

This month, we publish our annual reference issue, which is designed to provide skeletal information about ISMS and government agencies which influence health care in Illinois. We hope you find it to be useful.

The content of *IMJ* is meant to inform, explain and provoke the reader to contemplate new ideas and old ways. We count on you, the physician, to support *IMJ* as an educational vehicle and an idea forum.

We encourage you to consider *IMJ* the next time you have a clinical article, letter to the editor or guest editorial to publish. We urge you to suggest that your colleagues and students do the same. Instructions for submission are published in each issue.

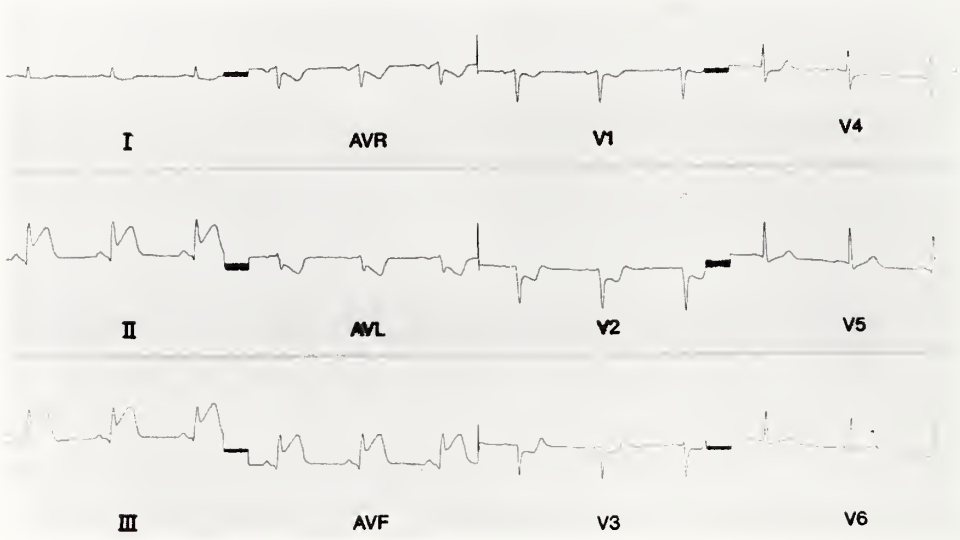
Our intent is to continue the job we've been doing with the *Journal:* to provide a common ground for discussion, to inform, explain and provoke thought. Take part in the Illinois physicians' dialogue. We can only succeed with your continued support.

J. William Roddick Jr., M.D.
Chairman, *IMJ* Editorial Board

EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a 59 year old man who presented with a complaint of chest pain. The chest pain was substernal and radiated to the right side of his neck. The pain had started after dinner with some nausea and had been present for three hours. He had a history of stable angina which always responded to nitroglycerine sublingually. This time the nitroglycerine failed to relieve the pain. His physical examination showed a blood pressure of 130/70mmHg. The heart exam was normal with no murmurs. A chest X-ray was normal. This twelve lead ECG was obtained.



Questions:

1. **The ECG shows:**
   A. Accelerated idioventricular rhythm.
   B. An inferior current of injury.
   C. Intermittent left bundle branch block.
   D. Reciprocal ST segment changes.
   E. Atrioventricular dissociation.

2. **The following would be appropriate measure(s) of treatment:**
   A. Admission to the coronary care unit.
   B. Measurement of cardiac enzymes.
   C. Serial twelve lead ECG recordings.
   D. Digoxin therapy.
   E. A temporary demand pacemaker.

(Continued on page 259)

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride
(80 mg, 120 mg, 160 mg Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
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Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. **8511/783**

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New York, N.Y. 10017

Obituaries

Belyea, R.J., Rock Island, died August 21, 1983 at the age of 84. Dr. Belyea was a 1929 medical school graduate.

Bradley, Nelson J., Detroit, died June 28, 1983 at the age of 65.

***Cawley, John E.,** Park Ridge, died July 8, 1983 at the age of 61. Dr. Cawley was a 1952 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Durkin, Thomas James,** Rock Island, died August 27, 1983 at the age of 62. Dr. Durkin was a 1952 graduate of Northwestern University Medical School, Chicago.

***Eckberg, E. Marvin,** Galva, died July 18, 1983 at the age of 67. Dr. Eckberg was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

****Evans, E. Graham,** Naples, Florida, died July 19, 1983 at the age of 76. Dr. Evans was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

***Hemmens, Elizabeth Seley,** Chicago, died August 4, 1983 at the age of 68. Dr. Hemmens was a 1950 graduate of the University of Illinois College of Medicine, Chicago.

***Irvine, Paul,** Highland Park, died August 13, 1983 at the age of 68. Dr. Irvine was a 1942 graduate of Rush Medical College, Chicago.

****Martin, Cecil,** Belleville, died August 31, 1983 at the age of 80. Dr. Martin was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

***Lee, Chang Ling,** Oak Park, died August 18, 1983 at the age of 66. Dr. Lee was a 1943 graduate of the West China Union University College of Medicine and Dentistry, Chengtu, Szechuan, China.

****McCann, Oria Marcellus,** Adrian, died July 7, 1983 at the age of 93. Dr. McCann was a 1923 graduate of the St. Louis University School of Medicine, St. Louis.

****McLean, Helen Vincent,** Chicago, died August 1, 1983 at the age of 89. Dr. McLean was a 1925 graduate of the University of Illinois College of Medicine, Chicago.

****McNally, Andrew,** Chicago, died August 4, 1983 at the age of 83. Dr. McNally was a 1925 graduate of the University of Illinois College of Medicine, Chicago.

***McNally, Howard James,** Chicago, died August 21, 1983 at the age of 73. Dr. McNally was a 1936 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Park, George Elliott,** Chicago, died August 8, 1983 at the age of 87. Dr. Park was a 1921 graduate of The Hahnemann Medical College and Hospital, Chicago.

***Piper, Chas Henderson,** M.D., Englewood, Florida, died July 31, 1983 at the age of 60. Dr. Piper was a 1923 graduate of Rush Medical College, Chicago.

****Pugh, Cloyd L.,** Ridge Farm, died August 8, 1983 at the age of 73. Dr. Pugh was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

****Rebillot, Joseph Robert,** Litchfield, died August 13, 1983 at the age of 79. Dr. Rebillot was a 1932 graduate of the Washington University School of Medicine, St. Louis.

***Sazma, Russell James,** Oak Lawn, died August 26, 1983 at the age of 67. Dr. Sazma was a 1939 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Staron, John Mathew,** La Grange Park, died August 15, 1983, at the age of 75. Dr. Staron was a 1942 graduate of the University of Health Sciences, Chicago Medical School.

***Yarbrough, Charles L.,** Cairo, died July 29, 1983 at the age of 66. Dr. Yarbrough was a 1941 graduate of the Washington University School of Medicine, St. Louis.

**Indicates ISMS member.*
***Indicates member of Fifty Year Club.*

EKG

(Continued from page 248)

Answer: 1. B, D 2. A, B, C.

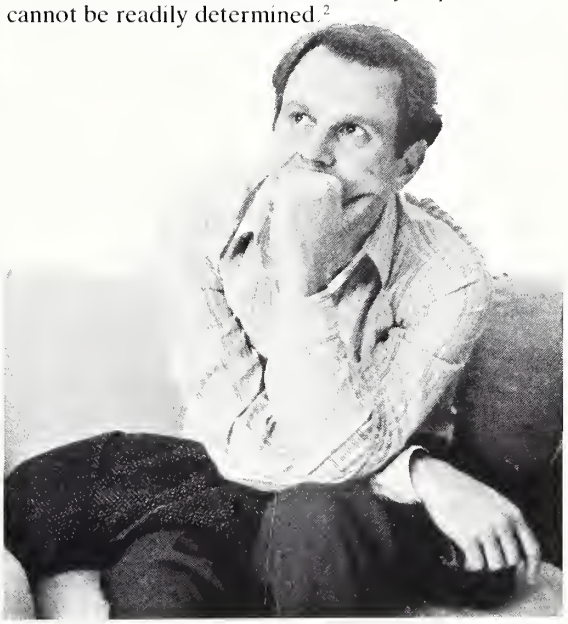
Sinus P waves are present throughout the ECG with a normal PR interval. A current of injury or elevated ST segment is present in leads II, III, and AVF, the inferior leads. Reciprocal ST segment depression is present in leads AVL, V_2 and V_3. The QRS duration is normal at 0.08 seconds. There is no evidence of any ventricular arrhythmia or atrioventricular dissociation. Although no significant Q waves are yet present, the inferior current of injury on the ECG and the history given by the patient are evidence of an acute inferior wall myocardial infarction. Admission to the coronary care unit and monitoring of the cardiac enzymes and ECG are appropriate. No congestive heart failure or heart block is present so digoxin and a pacemaker are not indicated. The significance of anterior ST segment depression seen here in leads V_2 and V_3 has recently been reviewed.[1,2] Marked ST segment depression has been associated with posterolateral ischemia or infarction in addition to the inferior wall damage.[1] These abnormalities in the posterolateral left ventricular wall were found by radionucleotide angiography in patients with inferior myocardial infarctions and a sum of ST segment depression in leads V_1 to V_4 greater than 0.45 m.v.[1] Another study has related this anterior ST segment depression to silent disease in the left anterior descending coronary artery.[2] This ECG finding generally means more global and regional ventricular dysfunction. Our patient developed angina three months after this uncomplicated myocardial infarction. Cardiac catheterization at that time demonstrated severe triple vessel coronary disease as well as inferolateral ventricular dysfunction.

References

1. Goldberg, H.L., *et al.:* "Anterior ST Segment Depression in Acute Inferior Myocardial Infarction: Indicator of Posterolateral Infarction," *Amer J Cardiol* 48:1009-1015, 1981.
2. Salcedo, J.R., *et al.:* "Significance of Reciprocal ST Segment Depression in Anterior Precordial Leads in Acute Inferior Myocardial Infarction: Concomitant Left Anterior Descending Coronary Artery Disease?" *Amer J Cardiol* 48:1003-1008, 1981.

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5,000,000 hospital patients with infections.[1] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[2]



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THE MULTIVITAMIN/MINERAL FORMULATION

1. Dixon RE: *Ann Intern Med 89*(Part 2):749-753, Nov 1978. *2.* Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1114.

Please see summary of product information on reverse page.

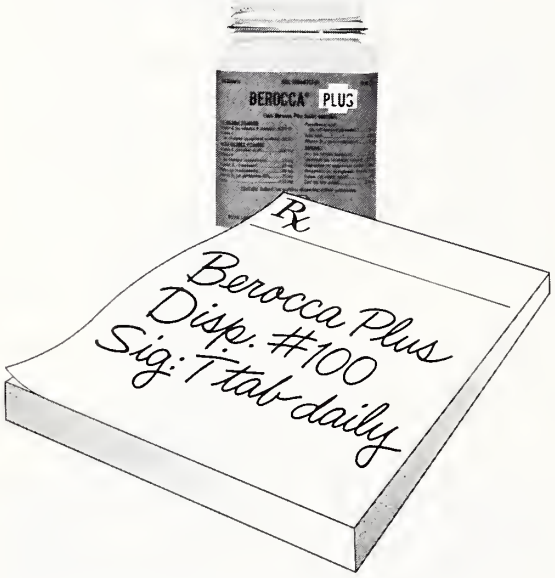
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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

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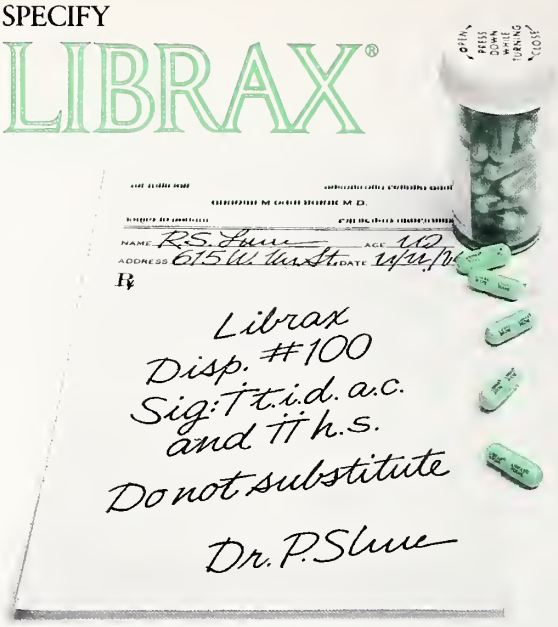
DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets — bottles of 100.

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* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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SPECIFY ADJUNCTIVE

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

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A Second Opinion

In July we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

A Rose Is a Rose Is a Rose?

Dear Editor:

I must report on a discussion that occurred while I was reading my other favorite journal—the *Wall Street Journal*—in Frank's Clipping Post. One of the opportunities offered by a retirement is that of reading and writing. Turns out writing is a far sight cheaper than reading, although gratuitous subscriptions (thank you *IMJ*) do help and knowing who gets what reading material is another aid. Fortunately there is enough time to travel from pillar to post, so to speak, and get all of my reading done during the day. This cost awareness probably wasn't as sharp when the money was coming in but now that I have a cap on my income, I have sharpened my budget pencil. Nothing is ever pure and simple, I realize, and cost awareness is really only part of it. I suspect that deep down, I am something of a literary voyeur since I have always preferred reading a newspaper over someone else's shoulder to holding it in my hand, and now have something of a license for voyeuring from place to place about town. But to return to the report of that discussion; let me set the scene.

The place was our barber shop, *Frank's Clipping Post.* I was sitting in the corner chair with the chrome arms reading the *Wall Street Journal,* Smitty was in the barber's chair and Old Asa was sitting in the far corner reading a 1979 *Field and Stream* when Lou Clark walked in. Lou rubbed his upper abdomen, belched several times and his innards growled audibly. With those kinds of openers, you can see that the conversation that follows would certainly be of high quality. Well, Lou grumbled about the indigestible combustibles he had just taken on board at the Apollo Cafe and then added another grumble about the cost. "Now take them Chinese Restaurants," started Lou. We all knew that any event would allow Lou to reference one of his three trips to St. Louis and "A happening on his travels." Locally known as *"Light Foot Lou,"* he got more mileage out of those three adventures than John Glenn did of his trips around the planet. "When you order from column A or Column B, you always know what it is going to cost, even though the sub-gum may be different," said Lou.

Frank being the philosopher type of barber jumped into the discussion, pointing out that columnizing the Apollo's cooking would be a challenge to tax most men. "Perhaps it could be done on the degree of heartburn and dyspepsia," observed Frank. From there the discussion moved toward clarification. "Instant-searing heartburn," (and there were a number of burnt offerings in that classification) could represent one group, "delayed dyspepsia" another, and so on down the line to a last classification as "simple distress." Well, that all sounded pretty good and everybody felt rather smug and satisfied until Asa added his two cents; saying, "Grouping and a known menu charge sounds pretty good to the pocketbook. However, even with Dyspepsia Related Grub, the groupings are after the swallowing." Sounds like retrospective

payment on those **D**yspepsia **R**elated **G**roups, doesn't it? "There's alot of those groupings around now and I'm not too keen on some of them as it is."

With that, Asa took off his straw hat and dusted off his shiny pate, fluffing up the fringe just above his ears and across the back of his neck. "Now I pay the same for a haircut, such as it is, as does Smitty, setting up there in the chair with half a floor full of shorn locks. That kind of grouping in charging don't make no sense at all. While it may be true that 'a rose is a rose is a rose,' it ain't necessarily true that a haircut is a haircut is a haircut!" Asa as usual sorted out the chaf from the wheat and put his finger on the difference between the pocketbook and the stomach and that a haircut is not necessarily a haircut is not necessarily a haircut.

Seems to me that you boys in the doctoring profession are going to have a little trouble with your DRGs too. May even cause a little indigestion or heartburn, like LFL's **D**yspepsia **R**elated **G**rub. However, there are some things in life that we just have to learn to live with or without, like haircuts, and since you fellas take your roots right back to the barber surgeons, I am sure you'll be able to make the transition and deal with it just like Frank has over the years.

Little disturbing to me to think about that fact, however, because as I later watched Frank perform on Asa, he spent a lot of time clipping those scissors where there weren't no hair. Well, I am sure you'll work it out and I do appreciate reading about DRGs and all them other initials.

Ys. Truly,



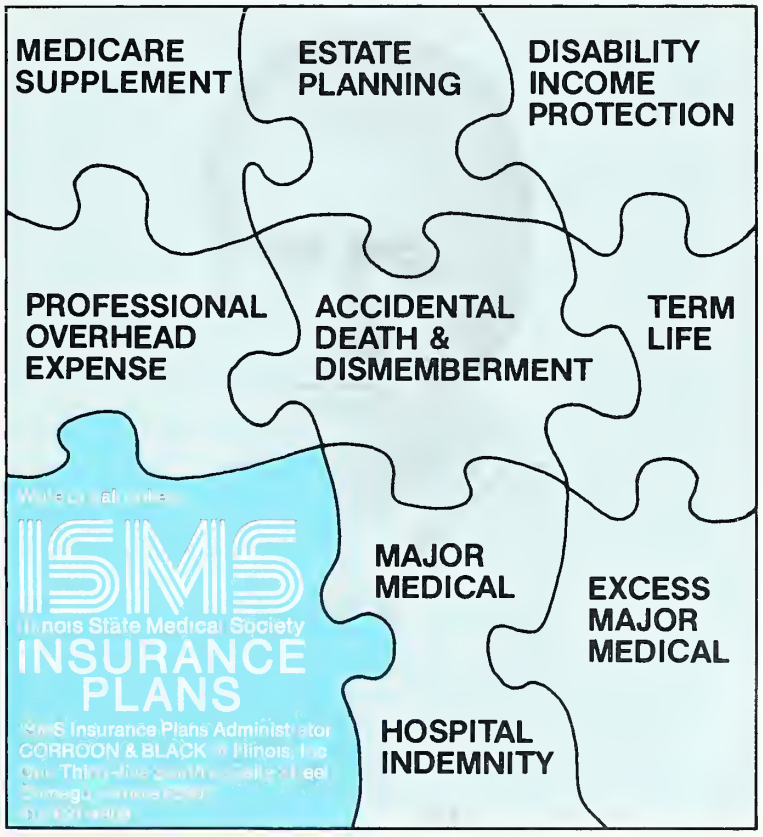
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- cardiac stress testing
- thallium myocardial
- ejection fraction
- pulmonary perfusion and ventilation
- brain, spleen, bone, liver, kidney, thyroid, bone marrow
- flow studies
- gallium
- all in vivo procedures
- quantitative bone analysis

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- obstetrical
- pelvic
- aortic
- special thyroid

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- standard fluoroscopy image intensification with TV
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*Additional NMR information on page 350

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ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by the present executive administrator, Mr. Alexander R. Lerner, in May, 1981.

The Society published the early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. VanDellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established under chairmanship of Dr. J. William Roddick, Jr., to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

ISMS Code of Ethics

WHEREAS, The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient; and

WHEREAS, As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; therefore be it

RESOLVED, That the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.

3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.

4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.

5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.

7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the Illinois State Medical Society
House of Delegates
November, 1981

ILLINOIS STATE MEDICAL SOCIETY

Constitution And Bylaws

Adopted, 1903
As Amended, 1983

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.
Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.
Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

D. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of these present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. *Student Members.* Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of

Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues.* Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments.* In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III.
EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section and 9) one delegate elected by the Medical Student Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meetings.*

A. Annual Meeting. The House of Delegates shall meet in an annual session and may meet in an interim session upon call of the Board of Trustees. The time and place of the annual meeting shall be as the House determines.

B. Interim Meeting. The Board of Trustees may schedule an interim session of the House of Delegates between annual meetings of the House if it determines that there is sufficient, relevant business. An interim meeting of the House should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. An interim meeting should be held in a district other than that of the preceding annual meeting.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special Meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was ealled.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a partieular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. The only

business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.
4. Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. *Judicial Panel.* The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. *The President-Elect.* The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice presidency, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom, or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. *Delegates and Alternate Delegates to the American Medical Association.* Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies estab-

lished by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member having all privileges except the right to vote. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—DuPage County.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. *Duties.* The duties of the Board of Trustees are executive and custodial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority. The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

   The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

   No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

   All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board. The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

   All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective. Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. *Quorum.* Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the

condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem appropriate to be held in a fund of a separate incorporated entity known as "The Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions and bequests to the Illinois State Medical Benevolence Fund, Inc., shall be deposited forthwith in said fund.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. Committees Reporting Directly to the Board of Trustees
C. House of Delegates Committees
D. Board of Trustees Committees

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:
   1. Liaison with the Illinois Bar Association
   2. Liaison with courts, particularly where impartial medical testimony is involved.
   3. Implementation of the Impartial Medical Testimony Rule
   4. Legal aspects of medical practice other than in the area of mental health
   5. Licensing and standards of practice
   6. Quackery
   7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
   1. Federal and state legislation—analysis and communication
   2. Legislative liaison—both state and federal
   3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
   1. Liaison with medical schools, curricula, etc.
   2. Health manpower and training
   3. Internships, residencies, etc.
   4. Scientific assembly
   5. Student loans
   6. Continuing medical education

D. The Council on Economics shall be concerned in the areas of:
   1. Ongoing relationships with third parties
   2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:
   1. The provision of medical care and health services in the public and private sectors
   2. Emergency medical services
   3. Health care of the poor, aged and those in rural areas
   4. Maternal and child health
   5. Nutrition
   6. Workmen's compensation
   7. Environmental and community health
   8. Rehabilitation
   9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
   1. Publicity and promotion
   2. News media relations
   3. Exhibits and public service programming
   4. Religion and medicine
   5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
   1. Facilities and services
   2. Liaison with Department of Mental Health
   3. Legal aspects of commitment, etc.
   4. Narcotics and dangerous drugs
   5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:
   1. Liaison between the affiliate society and ISMS
   2. Scientific resource information and advice to ISMS
   3. Consultation to other councils, *e.g.*, postgraduate education, health care delivery, publicity, legislation
   4. Advances of medical science in special fields

5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society
6. Affiliate Societies
   a. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
      1. as may be approved by the Board of Trustees
      2. which desire representation on the Council on Affiliate Societies
   b. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 3. *Organization of Councils.*

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physician members nominated by the Governing Council of the ISMS Resident Physicians Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

Section 4. *Task Forces.* A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

Section 5. *Committees Reporting Directly to the Board of Trustees*

A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.

B. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.

C. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.

D. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

E. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.

F. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to

local peer review committees and monitors activities around the state.

G. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

Section 6. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.

It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.

C. Committee on Tellers and Sergeants-at-Arms shall:

1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 7. *Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote. The chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society. This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of

the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*
It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.
It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.
It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*
It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.
The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. CME Accreditation Appeal Panel. The panel will consist of seven trustees. It will function as a hearing committee when a CME sponsor appeals a decision of the CME Accreditation Committee. The hearing shall be conducted in conformance with written procedures adopted by the Board of Trustees.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 9. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 10. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.

CHAPTER XI. ETHICAL RELATIONS

Part 1. *Component Medical Society.* Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings.*

Part 2. *District Ethical Relations Committee.* The delegates in each Illinois State Medical Society district, except in a single

county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee serving its area function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relation Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

Part 3. *Offenses.*

A. Disciplinary action may be taken against any member of a component society when:
   1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
   2. He has been adjudged or otherwise recorded as guilty by his component society of:
      a. acts of serious misconduct as a physician; or
      b. a violation of the Constitution or Bylaws of his component society, or of the code of Medical Ethics promulgated by the Illinois State Medical Society; or
   3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

Part 4. *Standards and Procedures.*

A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.

B. Disciplinary action may be initiated by the component society or the Illinois State Medical Society upon receipt of formal written charges filed by a licensed physician practicing or residing in the State of Illinois alleging violations of any of the offenses enumerated in this Part 3. Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

Part 5. *Penalties.* The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership. A decision based on a recommendation to acquit shall be final and not appealable.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to this expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

Part 6. *Decision by Component Medical Society.*

A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

Part 7. *Judicial Panel.* A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individuals physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel,

one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws.

In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees. The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as necessary in order to assure a reasonably prompt dispositon of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings,* to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

Part 8. *Due Process Safeguards.* In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

CHAPTER XII PEER REVIEW

Part 1. *Definitions.* Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted by the county society where the physician holds membership or where the incident which served as the basis for the peer review complaint occurred. Ethical relations issues identified during deliberations of the county peer review committee, or where appropriate, the District Peer Review Committee may be referred to either the county or district ethical relations committee, as deemed appropriate by the county (district) committee.

Should an adverse decision be made against a physician by a county society where the reviewed practitioner does not hold membership, that decision will have the weight and effect of a decision made by his own county society. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

Part 2. *Component Society Procedures.*

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society or district committee. A petition for an appeal must set forth one of the following grounds as a basis for the appeal:

1. PROCEDURAL ERROR—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.
2. BIAS—The proceeding was conducted in a biased or arbitrary manner.
3. INCOMPLETE INFORMATION—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient

who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

Part 3. *District Committee.* The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

Part 4. *Illinois State Medical Society Procedures.*

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

   The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1983-1984

Policy Manual

of the

Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."
"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—

(2) refer the statement to the Board for reconsideration and subsequent report—

(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

PROFESSIONAL POLICIES

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement.
(Amended, 1980 Annual Meeting)

Abuse and Neglect of the Elderly

Physicians, nurses and other health care personnel are reminded to be aware of possible instances of abuse and neglect of the elderly and are encouraged to report suspected cases appropriately.
(1982 Annual Meeting)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists.
(1975 Annual Meeting—Reviewed by Board 1980)

Advertising Guidelines, Physician Professional

In keeping with the Principles of Medical Ethics, as well as rules of law, the following advertising guidelines are adopted:

I. General
These guidelines shall apply to solo practitioners and groups of physicians, including medical clinics, HMOs, and other physician-operated facilities. The medical society recommends that these guidelines be suggested for hospitals and other health care institutions. The medical society does not look with favor upon advertisements which promote or produce unfair competition.

II. Acceptable Professional Identification
1. Name, with earned degree(s)
2. Office address and telephone
3. Home address and telephone
4. Answering service
5. Office hours
6. Medical specialization
7. Board certification
8. Type of practice (group, solo) and affiliation, so long as such identification is not misleading
9. Hospital affiliation
10. Foreign language competence
11. Usual and customary fees, for routine medical service. Such fee identification must include notification that fees may be adjusted in the event that complications or unforseen circumstances arise. The usual and customary fee quoted shall be that fee charged to the majority of patients seeking the same basic service. Such fee identification must not be misleading. Average charges may not be stated.
12. Public announcement of changes in any of the above

III. Professionally Unacccptable
1. Testimonials or anecdotal reports of medical practice success
2. Claims of superior quality of care
3. Fee comparisons of available services with those of other licensed physicians or medical clinics
4. Listing of professional service which the offerer is not qualified to provide
5. Statements which contain false, fraudulent, deceptive or misleading material
6. Warranties or guarantees of success or unsuccessful therapy
7. Statements which play upon the fears and vanities of the public
8. Display or similar advertising that may serve to mislead or misinform the public
9. Solicitation of media coverage of medical services by means of "news stories" designed for personal or financial gain

IV. Media Guidelines
1. Newspapers and magazines
   a. Type size shall be that text type used in the publication
   b. Use of any ornaments, embellishments, or symbols is prohibited
2. Professional or business cards, and office signs giving allowable information are permissible
3. Health care services directories (including telephone directories) are subject to the same policies as stated under newspapers and magazines above

(1979 Annual Meeting)

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics.
(Amended, 1980 Annual Meeting)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged.
(Amended, 1980 Annual Meeting)

Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.
(Amended, 1980 Annual Meeting)

Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.
(1981 Annual Meeting)

Animals in Research and Education

The Illinois State Medical Society endorses the position that research and medical education, which involves the use of animals, is necessary to enhance the medical care of the public.
(1983) Annual Meeting)

Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds or other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.
(Amended, 1980 Annual Meeting)

Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.
(Amended, 1980 Interim Meeting)

Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additionally, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.
(Amended, 1980 Interim Meeting)

Autopsies

Because the autopsy has educational benefits for medical science as well as the family of the deceased individual, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.
(1978 Interim Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.
(Reviewed, 1980)

Blood Availability

The Illinois State Medical Society encourages component societies to support abolition of blood bank replacement deposit fees (often referred to as penalty or non-replacement fees).

The Illinois State Medical Society and its component societies encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.
(1979 Annual Meeting)

Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.
(Amended, 1980 Interim Meeting)

Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.
(1981 Annual Meeting)

Child Abuse

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the family environment prior to the release of the child for return to the same home where the abuse occurred.
(1981 Interim Meeting)

Child Safety Restraints

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.
(1981 Interim Meeting)

Code of Ethics

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and

use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

(1981 Interim Meeting)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness. Section IV of the Principles of Medical Ethics states that: "A physician shall respect the rights of patients . . . . . and shall safeguard patient confidences within the constraints of the law." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in opposition to the use of the Social Security number as a universal number identifier.

(Reviewed, 1981)

Continuing Education

Continuing education is one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multifaceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have the primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities.

ISMS urges the Illinois Department of Registration and Education to notify by certified mail physicians who are to be audited for CME credits in connection with relicensure.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

Financial support for the Illinois Council on Continuing Medical Education is provided by the Board of Trustees of ISMS. ICCME shall prepare an annual financial report for the House of Delegates indicating (a) major sources of income, (b) major categories of expenditure and (c) a proposed budget for the year in which the House is meeting.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.

(Amended, 1982 Interim Meeting)

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services, should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.

(Amended 1983 Annual Meeting)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.

(1977 Annual Meeting)

Death, Legal Definition of

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

(Amended, 1981 Interim Meeting)

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based upon what must necessarily be a private matter between physician and patient. If passage of such legislation is imminent, it must provide immunity from civil and criminal penalties for physicians who act in good faith and in accordance with accepted medical practice and must not require physicians to act

in violation of their own personal beliefs, morals and conscience.
(Amended, 1981 Annual Meeting)

Diagnosis Related Groups

ISMS supports the concept that the individual hospital medical staffs' responsibility is to ensure that appropriate quality of care for patients shall not be compromised in the Diagnosis Related Groups (DRG) process.
(1983 Annual Meeting)

Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.
(Amended, 1980 Annual Meeting)

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Only those generic drugs which are actually bio-equivalent should be included in the Illinois Formulary for the Drug Product Selection Program of the Illinois Department of Public Health.

ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.
(Amended, 1982 Annual Meeting)

Drunk Drivers

ISMS supports laws providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.
(1981 Interim Meeting)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.
(1976 Annual Meeting—Reviewed by Board 1981)

Emergency Medical Care, Provision of

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

The Illinois State Medical Society encourages the State of Illinois and the business community to provide an emergency medical kit and qualified individuals for the administration of appropriate emergency care at functions where a very large number of individuals are present.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.
(Amended, 1983 Annual Meeting)

Ethics

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.
(1979 Interim Meeting)

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.
(1966 Annual Meeting—Reviewed by Board 1980)

Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

Accepted ethical standards;

The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;

Appropriate Illinois statutory or regulatory requirements.
(Amended, 1981 Annual Meeting)

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.
(1976 Annual Meeting—Reviewed by Board 1980)

55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.
(1981 Annual Meeting)

Firearms

The Illinois State Medical Society supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. It opposes any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition.
(1982 Annual Meeting)

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is

encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a state-wide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.
(1977 Interim Meeting)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.
(1976 Interim Meeting—Reviewed by Board 1981)

Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.
(1978 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.
(1977 Interim Meeting)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.
(1967 Annual Meeting—Reviewed by Board 1980)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.
(Amended, 1979 Interim Meeting)

Health Insurance, Voluntary Plans

ISMS supports private, voluntary catastrophic health insurance, including freedom of choice of physician. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for ambulatory diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of the money from the patient should be the responsibility of the insurance company, or its agent, that commited the error and not the responsibility of the physician.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physician's charges above insurance benefit allowances are excessive;
- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- Suggesting that physicians perform alternative surgical procedures;
- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;

- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and
- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1982 Annual Meeting)

Health Maintenance Organizations

Every insurance identification card for a health maintenance organization should have the designation, "HMO," clearly printed on the front of the insurance card, along with the warning that unauthorized services may not be reimbursed and along with a 24-hour telephone number which can be called for payment approval in the event of an emergency.
(1982 Interim Meeting)

Health Planning

ISMS supports health planning on a local and voluntary basis with input by a significant number of physicians licensed to practice medicine in all its branches. Planning and implementation of the plan (regulation) are two different processes and should be kept separate and distinct.
(Amended, 1982 Annual Meeting)

Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.
(1974 Annual Meeting—Reviewed by Board 1980)

Health Systems Agencies

The Illinois State Medical Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.
(1981 Annual Meeting)

HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.
(1980 Annual Meeting)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.
(1977 Annual Meeting)

Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either in-patient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.
(1981 Annual Meeting)

Hospital and Medical Staff Committees

A hospital's medical staff should be an autonomous, self-governing body whose members participate in the activities of medical staff and hospital committees. However, physicians should distinguish between committees where the hospital gives the staff authority and responsibility and those where the hospital has full responsibility. Medical staff committees should be those composed solely of members of the medical staff and concerned with the quality of medical care. Hospital committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, that may or may not include medical staff members.
(1982 Interim Meeting)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. The hospital medical staff and only the medical staff should establish minimum limits of professional liability insurance coverage for their own medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on the medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of the hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.
(Amended, 1982 Interim Meeting)

Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society supports physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be

shown that continuation of the physician in practice is not in the best interest of his/her patients.
(1980 Annual Meeting)

IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bio-equivalence.
(1981 Annual Meeting)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.
(Amended, 1981 Annual Meeting)

Indigent, The Care of the

The Illinois State Medical Society reaffirms organized medicine's commitment to provide care to those who need medical care, regardless of their ability to pay for it.

However, personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.
(Amended, 1982 Interim Meeting)

Informed Consent

ISMS endorses the position that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which are disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

ISMS opposes legislative definition of informed consent.

However, it favors enactment of legislation providing that consent for furnishing medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.
(Amended 1982 Interim Meeting)

Joint Commission on Accreditation of Hospitals

A "physician" (doctors of medicine or doctors of osteopathy) is defined as one who by education, training, experience, and licensure is able to practice medicine in all of its branches. ISMS encourages the Joint Commission on Accreditation of Hospitals to require greater than a majority of fully licensed physician membership on the medical staff executive committees in acute care general hospitals. ISMS urges JCAH to recognize the importance of the medical staff in credentialing and in monitoring the quality of care in the hospital and it encourages the development of the appropriate environment within the hospital so that both the medical staff and limited licensed practitioners may work together for the best interests of the patient.
(1983 Annual Meeting)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.
(Amended, 1980 Interim Meeting)

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.
(1981 Annual Meeting)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.
(1976 Annual Meeting—Reviewed by Board 1980)

Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.
(Amended, 1980 Annual Meeting)

Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

It favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

It supports the philosophy that all medical education accepted for licensure to practice should be comparable.

Graduates of state medical schools are encouraged to practice medicine in Illinois and ISMS will utilize its organizational structure to develop positive incentives.

ISMS encourages primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.
(Amended, 1982 Interim Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coroner system, wherever practical.
(1971 Annual Meeting—Reviewed by Board 1980)

Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.
(1979 Annual Meeting)

Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

ISMS supports the concept that when federal funds are available to the states, physicians should actively participate in the distribution of these funds.
(Amended, 1982 Interim Meeting)

Medical Staff Participation in Accreditation Activities

Medical staff of a hospital should cooperate to achieve JCAH accreditation of their hospital.
(1982 Interim Meeting)

Medical Staff Participation in Hospital Cost Containment Efforts

Physicians on a hospital's medical staff should encourage and cooperate in efforts to see that hospital care is delivered in the most effective manner without compromising quality.
(1982 Interim Meeting)

Medical Staff Relationship with County Medical Society

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health related agencies in their community.
(1982 Interim Meeting)

Medical Supplies, In-Flight

The Illinois State Medical Society encourages air carriers to equip planes with an emergency kit on each flight and that flight crews be instructed in cardio-pulmonary resuscitation procedures.
(1982 Interim Meeting)

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness, must satisfy the definition of an expert witness that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.
(1977 Annual Meeting, Reviewed, 1981)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.
(Amended, 1980 Annual Meeting)

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.
(1980 Interim Meeting)

Mental Health

The Illinois State Medical Society strongly opposes a double standard of care in state hospitals.

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.

3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.

All physician or other health service provided to the DMHDD, other than that by fulltime employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches and a physician licensed to practice medicine in all of its branches should be required to certify the discharge of any patient from a psychiatric institution.
(1977 Annual Meeting, Reviewed by Board, 1981)

Motorcycle Helmets

All Illinois physicians should encourage their patients who use motorcycles to wear protective helmets, pointing out the efficacy of such helmets in preventing death during collisions.
(1982 Annual Meeting)

Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.
(Amended, 1980 Interim Meeting)

Nurses-Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.
(1970 Annual Meeting—Reviewed by Board 1980)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.
(1973 Annual Meeting—Reviewed by Board 1980)

Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.
(Amended, 1980 Annual Meeting)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged.
(Amended, 1980 Interim Meeting)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting)

Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of nonhospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Sections 71, 73 and 101; Chapter 91½, Section 800ff.
(Amended, 1981 Annual Meeting)

Peer Review

See Chapter XII of the Bylaws.
(Amended, 1983 Annual Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take whatever action is necessary to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(1978 Interim Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."
(Amended, 1981 Interim Meeting)

Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.
(1980 Annual Meeting)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.
(1976 Annual Meeting)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting—Reviewed by Board 1980)

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multispecialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multi-specialty care for Public Aid patients should be made available without extensive justification procedures.
(Amended, 1981 Interim Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.
(Amended, 1980 Annual Meeting)

Rehabilitation

All physical rehabilitation activites should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.
(Prior to 1965—Reviewed by Board 1980)

Reimbursement of Ambulatory Services

Third party payors should be encouraged to provide coverage for ambulatory surgery and diagnostic procedures. Final medical decisions must remain in the hands of the attending physician. However, the Illinois State Medical Society supports the concept of maximum utilization of ambulatory surgical services consistent with the doctor's judgment of the facilities available.
(Amended, 1982 Annual Meeting)

Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.
(1980 Annual Meeting)

Reimbursement for Out-Patient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.
(1980 Annual Meeting)

Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.
(1981 Annual Meeting)

Relationship with Third Party Payors

ISMS should provide guidance, education, communications, and negotiations between the membership and third party payors.

Seatbelt Use

The Illinois State Medical Society supports the voluntary use of seatbelts and other passenger restraint devices as effective methods of reducing injury and death in motor vehicle accidents. It supports state legislation requiring that all school buses be equipped with passenger safety restraints and other structural modifications to assure maximum impact safety.
(Amended, 1983 Annual Meeting)

Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Physicians and their employees should refrain from smoking during patient contacts.

Physicians should give advice and provide literature and signs concerning the health hazards of smoking.

ISMS encourages and supports efforts, legislative and otherwise, to ban or restrict smoking in all public places and the development of appropriate regulations to accomplish this.
(Amended, 1979 Interim Meeting)

Surgery, Reconstructive

Surgery to correct post-surgical deformities is reconstructive surgery.
(1979 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.
(1979 Annual Meeting)

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization over and above the judgment of the treating physician.
(1978 Annual Meeting)

Tobacco Farm Subsidies

The Illinois State Medical Society opposes the subsidization or price supports of tobacco farming.
(1982 Annual Meeting)

Usual and Customary or Reasonable Reimbursement

The Illinois State Medical Society endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule.
(1979 Annual Meeting)

Veterans Administration

The Illinois State Medical Society continues to support the concept that a Veterans Administration hospital should only be concerned with the needs of those patients with service-connected disabilities.
(Amended, 1980 Annual Meeting)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.
(1978 Annual Meeting)

Workers Compensation

The Illinois State Medical Society advocates a single radiologic examination to satisfy the medical requirements at a given time in the course of a workers compensation injury.
(1982 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.
(Amended, 1980 Interim Meeting)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.
(Amended, 1980 Interim Meeting)

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.
(1978 Interim Meeting)

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.
(1981 Annual Meeting)

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Registration and Education to the appropriate county society.
(1980 Interim Meeting)

Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates.
(1980 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.
(Amended, 1980 Annual Meeting)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.
(1977 Annual Meeting)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.
(1978 Annual Meeting)

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.
(1981 Annual Meeting)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.
(Prior to 1965—Reviewed by Board 1980)

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal;*
2. Brief notice in Action Report, whenever possible, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(1977 Annual Meeting)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.
(Prior to 1965—Reviewed by Board 1980)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.

Nomination for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.

Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.
(Amended 1981 Interim Meeting)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairman and county medical societies. Such inquiries shall be channeled through the Board of Trustees.
(Amended, 1980 Annual Meeting)

Legislation

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council, which shall evaluate its potential impact on the society's current legislative efforts. The council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Governmental Affairs Council of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee.
(Amended, 1981 Interim Meeting)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.
(1974 Annual Meeting—Reviewed by Board 1980)

Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.
(1978 Interim Meeting)

National Library of Medicine

The Illinois State Medical Society supports the programs of the National Library of Medicine. Fees for subscribers should be based on the current accounting system rather than on total costs.
(1982 Interim Meeting)

Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.
(Amended, 1980 Interim Meeting)

Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities

connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.
(1980 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.
(1976 Interim Meeting, Reviewed by Board, 1982)

Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.
(Amended, 1978 Interim Meeting)

Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.
(1978 Annual Meeting)

Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.
(1980 Annual Meeting)

Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.
(Amended, 1980 Interim Meeting)

Resident Physician Membership

Each regular member of ISMS is encouraged to recruit at least one resident physician member every year, with the regular member providing assistance to the resident in completing the application process for membership.

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.
(Amended, 1983 Annual Meeting)

Resident-Student Alternate Delegates to AMA

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.
(1979 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.
(1976 Interim Meeting)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.
(1979 Annual Meeting)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.
(1974 Annual Meeting—Reviewed by Board 1980)

Policy Manual Appendix

Statement of Understanding
(between patient and physician)

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

TRUSTEE DISTRICT COMMITTEES

First District

John J. Ring, Mundelein, Trustee
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
David Clark, Aurora, *Chairman*	1984
Emanuel Herzon, Elgin	1984
Gerald Liesen, St. Charles	1985
A. M. Rosetti, McHenry	1986

Peer Review Committee	
David Helberg, Waukegan, *Chairman*	1984
Eugene Pitts, Waukegan	1984
James Pritchard, Geneva	1984
Peter Vinceguerra, Libertyville	1984

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford

Ethical Relations Committee	Term Expires
William Erkonen, Streator, *Chairman*	1986
Karl T. Deterding, Pontiac	1986
Julius Kowalski, Princeton	1986
Lawrence D. Lee, Manhattan	1985
Merle Otto, Frankfort	1985
James Ryan, Kankakee	1985

Peer Review Committee	
Louis Tarsinos, Princeton, *Chairman*	1985
James B. Aplington, LaSalle	1985
Robert Betasso, Ottawa	1985
W.H. Brill, Oswego	1986
James E. Dailey, Watseka	1984
Silvio Davito, Spring Valley	1985
Bernard J. Doyle, LaSalle	1985
William Ehling, Streator	1986
Guy Pandola, Joliet	1984
A.G. Parkhurst, Kankakee	1986
Alex Spadoni, Joliet	1985
Theodore W. Wagenknecht, Streator	1985

Third District

James H. Andersen, M.D., Oak Brook, *Trustee*
Richard Blankshain, Oak Park, *Trustee*
Audley F. Connor, Jr., Chicago, *Trustee*
Morris T. Friedell, Chicago, *Trustee*
Henrietta Herbolsheimer, Chicago, *Trustee*
Harold L. Jensen, Flossmoor, *Trustee*
Arthur R. Peterson, Chicago, *Trustee*
Pedro A. Poma, Melrose Park, *Trustee*
Clifton L. Reeder, Wilmette, *Trustee*
Harry A. Springer, Evanston, *Trustee*

Fourth District

George Burke, Rock Island, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

Ethical Relations Committee	Term Expires
Earl Clark, Rock Island, Chairman	1984
Richard Icenogle, Roseville	1986
Jerry Ramunis, Victoria	1985

Peer Review Committee	
William Dougherty, Moline, Chairman	1984
Donald Dexter, Macomb	1986
G. W. Giebelhausen, Peoria	1984
James C. Parsons, Geneseo	1985
Clarence Ward, Peoria	1984
Richard Flacco, Galesburg	1985

Fifth District

Robert Prentice, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

Ethical Relations Committee	Term Expires
Richard H. Suhs, Springfield, *Chairman*	1986
Jack Means, Mason City	1984
A. L. Van Ness, Bloomington	1985

Peer Review Committee

James Borgerson, Mt. Pulaski, *Chairman*	1986
George Irwin, Bloomington	1985
Paul LaFata, Springfield	1986
Robert B. Perry, Lincoln	1985
Donald Yurdin, Springfield	1985
Clifford Draper, Hillsboro	1985
Albert Cunningham, Normal	1986

Sixth District

Robert R. Hartman, Jacksonville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Newton DuPuy, Quincy, *Chairman*	1986
Bernard Baalman, Hardin	1984
Edward K. DuVivier, Alton	1986
C. B. Lara, Pittsfield	1984
Robert Roy, Jacksonville	1984

Peer Review Committee

Walter Stevenson III, Quincy, *Chairman*	1986
E. C. Bone, Jacksonville	1985
Robert England, Carlinville	1984
Robert C. Murphy, Quincy	1985
Edward Ragsdale, Alton	1986
James Sutherland, Quincy	1986
Robert F. Hamilton, Alton	1984

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Delbert H. Hahn, Jr., Decatur, *Chairman*	1985
P. D. L. Nayak, Effingham	1984
Muhammad T. Salaymeh, Taylorville	1985
E. F. Stephens, III, Centralia	1985

Peer Review Committee

M. K. Kaufman, Greenville, *Chairman*	1986
H. Gale Zacheis, Decatur	1986
Clarence G. Glenn, Decatur	1985
D. H. Rames, Vandalia	1985

Eighth District

Arthur R. Traugott, Urbana, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1986
Charles L. Lansford, Urbana	1985
James H. Pass, Olney	1984
Stanley R. Huffman, Charleston	1986

Peer Review Committee

George T. Mitchell, Marshall, *Chairman*	1984
Edward S. Warren, Danville	1986
G. Carr, Lawrenceville	1985
R. C. Adams, Champaign	1985

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Alex Goldstein, Harrisburg, *Chairman*	1985
Eli Borkon, Carbondale	1986
Robert Rader, Anna	1986

Peer Review Committee

Philip D. Boren, Carmi, *Chairman*	1985
Larry Jones, Harrisburg	1984
Roger Klam, Carbondale	1984
Harry L. Lewis, Benton	1985
Eugene B. Loftin, Fairfield	1985
Charles K. Wells, Mt. Vernon	1985

Tenth District

Thomas P. Meirink, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Washington

Ethical Relations Committee	Term Expires
H. P. Dexheimer, Belleville, *Chairman*	1985
Roy Kenney, E. St. Louis	1985
Edilberto Maglasang, Columbia	1985
Wm. A. Simmons, Belleville	1985

Peer Review Committee

William H. Walton, Lenzburg, *Chairman*	1984
Benjamin Arenas, Belleville	1985
Ted Bryan, Belleville	1985
R. W. Jost, Waterloo	1984
R. E. Schettler, Red Bud	1986
Ron Welch, Belleville	1984

Eleventh District

Raymond A. Dieter, Jr., Glen Ellyn, *Trustee*
County of DuPage

Twelfth District

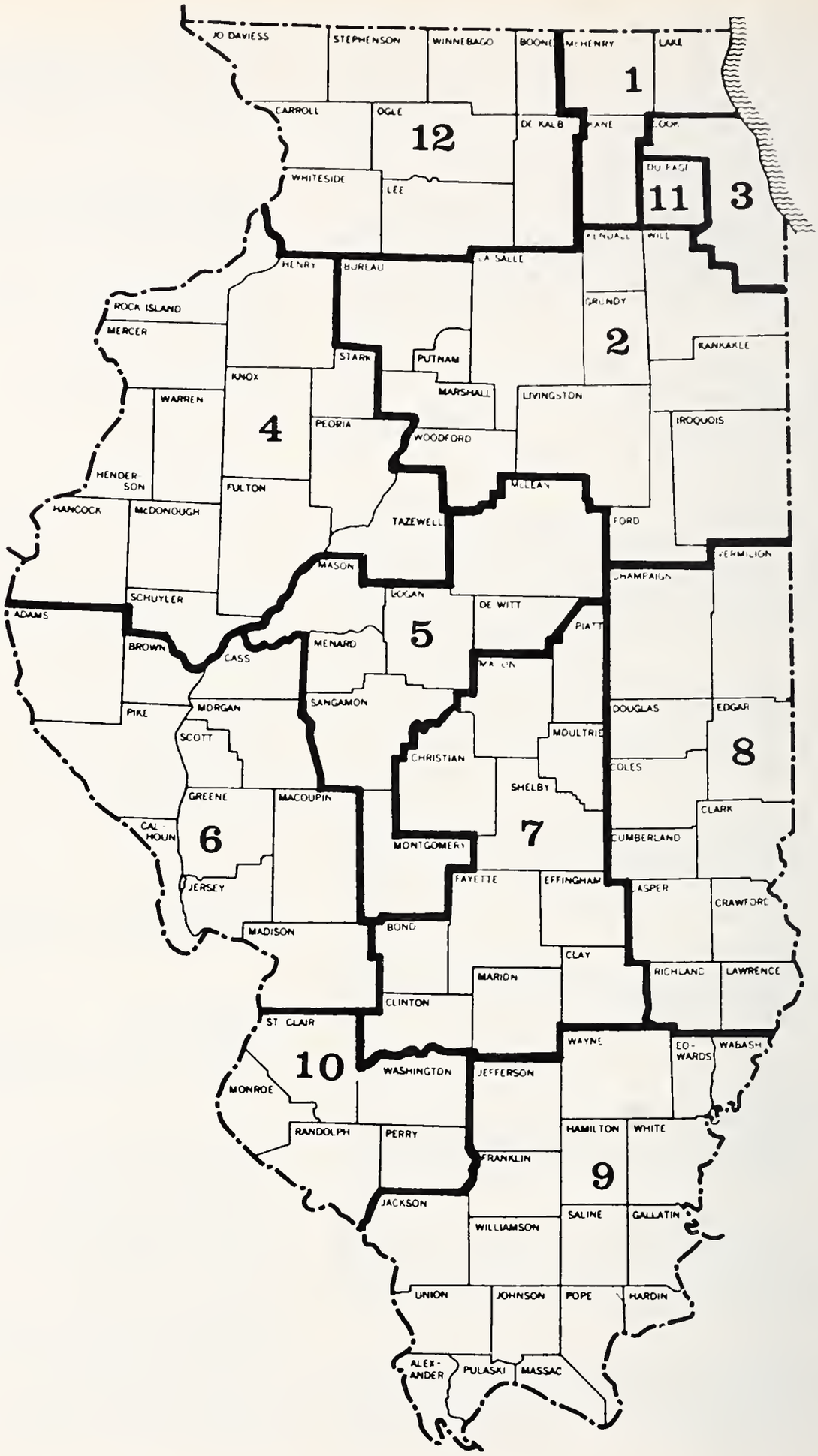
Raymond E. Hoffmann, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
P. John Seward, Rockford, *Chairman*	1983
William Isham, Freeport	1986
John W. Ovitz, Jr., Sycamore	1986
John H. Steinkamp, Belvidere	1984
James Topp, Rockford	1986
Richard S. Webb, Jr., Rockford	1986

Peer Review Committee

P. John Seward, Rockford, *Chairman*	1986
William Isham, Freeport	1986
John W. Ovitz, Jr., Sycamore	1986
John H. Steinkamp, Belvidere	1984
James Topp, Rockford	1986
Richard S. Webb, Jr., Rockford	1986

ISMS TRUSTEE DISTRICTS



1983 Officers
Of County Medical Societies

County	President	Secretary
Adams Members: 101-Dist 6 Maxine Boyer, Ex. Sec. 2039 Sunnybrook PO Box 767 Quincy 62306	Walter Stevenson III 1101 Maine, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
Alexander Members: 8-Dist. 9	Gemo Wong 529 Cross, Cairo 62914	Gemo Wong 529 Cross, Cairo 62914
Bond Members: 8-Dist. 7	Thomas D. Dawdy 100 N. Locust, Greenville 62246	Boyd A. McCracken 100 N. Locust, Greenville 62246
Boone Members: 26-Dist. 12	Earl S. Davis 119 S. State St., Belvidere 61008	John Steinkamp 824 S. Van Buren, Belvidere 61008
Bureau Members: 37-Dist. 2	Swasdi Pothikamjorn, 4040 Progress Blvd., Peru 61354	Mukund Godbole 530 Park Ave. E., Princeton 61356
Carroll Members: 7-Dist. 12	Lemuel B. Hussey P.O. Box 99, Savanna 61074	Cecil G. Piper 203 W. Market St., Mt. Carroll 61053
Cass-Brown Members: 1-Dist. 6		
Champaign Members: 252-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	Lewis Trupin 301 E. Springfield, Champaign, 61820	Paul W. Yardy 602 W. University, Urbana 61801
Christian Members: 21-Dist. 7	Muhammad T. Salaymeh 600 N. Main, Taylorville 62568	I. Del Valle 311 S. Main, Taylorville 62568
Clark Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay Members: 7-Dist. 7	Donald L. Bunnell Flora Clinic, Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
Clinton Members: 15-Dist. 7	Jonathan V. Osborn Medical Arts Bldg., Breese 62230	James A. Kirby 401 N. Main, Breese 62230
Coles-Cumberland Members: 65-Dist. 8	Ronald D. Miller Link Clinic, Mattoon 61938	Donald E. Binz 1810 Charleston, Mattoon 61938
Cook Members: 9681-Dist. 3 Fred Schwartz, Exec. Dir. 515 N. Dearborn St. Chicago, IL 60610	Alfred J. Clementi 675 W. Central Road Arlington Hts., 60005	Richard H. Blankshain 715 Lake St., Oak Park 60301
Crawford Members: 13-Dist. 8	Frank Gross 1002 Allen, Robinson 62454	W.B. Schmidt Schmidt Clinic, Robinson 62454
DeKalb Members: 60-Dist. 12	Paul Stromborg 954 W. State St., Syeamore 60178	William F. Staeh 407 W. State St., Syeamore 60178
DeWitt Members: 9-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas Members: 19-Dist. 8	Humberto Mondul 111 W. S. Central, Tuscola 61953	Grant A. Jones 318 S. Ash, Arthur 61911

County	President	Secretary
DuPage Members: 730-Dist. 11 Lillian Widmer, Ex. Admin. 800 Roosevelt Road Building B-Suite 300 Glen Ellyn 60137	WM. P. Gibbons Good Samaritan Hosp., 38th & Highland, Downers Grove 60515	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar Members: 16-Dist. 8	Duane Haskel 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham Members: 19-Dist. 7	Herbert F. Webb Marshall Clinic, Effingham 62401	Ruben Boyajian 606 W. Kentueky, Effingham 62401
Fayette Members: 9-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kaehgal 802 N. Eighth St., Vandalia 62471
Ford Members: 16-Dist. 2	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
Franklin Members: 24-Dist. 9	Yihnan Chiou 502 W. St. Louis St., Frankfort 62896	R. G. Thompson 309 W. St. Louis St., Frankfort 62896
Fulton Members: 38-Dist. 4	Jessie M. Reyes 210 W. Walnut, Canton 61520	Thomas C. Sehrepfer 511 Promenade, Hanava 62644
Gallatin Members: 2-Dist. 9		John E. Doyle Ridgway 62979
Greene Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
Hancock Members: 9-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Loeust, Carthage 62321
Henderson Members: 1-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	Silvino Lindo, Jr. Biggsville 61418
Henry-Stark Members: 34-Dist. 4	Luis Jose Garcia Kewanee Public Hosp., Kewanee 61443	Richard M. Terry 420 S. Chestnut, Kewanee 61443
Iroquois Members: 20-Dist. 2	Leslie Duis 845 S. 4th St., Watseka 60970	Leslie C. Duis 845 S. Fourth St., Watseka 60970
Jackson Members: 120-Dist. 9	Punnoose Pachikara 106 S. 14th St., Murphysboro 62966	Brain G. McElheny 404 W. Main, Carbondale 62901
Jasper Members: 2-Dist. 8	Monico Low 609 S. Van Buren, Newton 62448	Juan J. Serra 507 W. Washington, Newton 62448
Jefferson-Hamilton Members: 42-Dist. 9	Charles Longwell, Jr. #1 Doctors Park, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
Jersey-Calhoun Members: 11-Dist. 6	Kurella T. Sarma Maple Summit Rd., Jerseyville 62052	Bernard Baalman Medieal Center, Hardin 62047
Jo Daviess Members: 10-Dist. 12	David Hoekman 219 Summit St., Galena 61036	Franeis B. Waites 219 Summit St., Galena 61036
Kane Members: 330-Dist. 1 H. Michael Wild, Ex. Dir. 355 First St. Batavia 60510	Thomas Stemper 1870 W. Galena, Aurora 60506	Francis Oslay 1705 South St., Geneva IL 60134
Kankakee Members: 109-Dist. 2	Ray R. Schale 475 W. Merehant St., Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901

County	President	Secretary
Kendall Members: 8-Dist. 2	John P. Cullinan Main & VanBuren, Oswego 60543	Joseph Lee Daw Main & VanBuren, Oswego 60543
Knox Members: 80-Dist. 4 Mrs. Jane Gau, Exec. Sec. Galesburg Cottage Hospital 695 N. Kellogg Galesburg 61401	Edward S. Peterka 612 Bondi Bldg., Galesburg 61401	Subbia G. Jagannathan 695 N. Kellogg, Galesburg 61401
Lake Members: 437-Dist. 1 Jane R. Stein, Exec. Dir. 1117 S. Milwaukee Forum One—Suite 13 Libertyville 60048	J. Vickers Brown 1950 Sheridan Road Highland Park 60035	Allan B. Minster 135 N. Greenleaf, Grunee 60031
LaSalle Members: 102-Dist. 2	Robert F. Bettaso 1703 Polaris Circle, Ottawa 61350	Allan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence Members: 11-Dist. 8 Ruth E. Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Alexander Po RR 4, Lawrenceville 62439	Francisco E. Martin 542 N. Main, Bridgeport 62417
Lee Members: 25-Dist. 12	Robert J. Piha 101 W. Mason, Polo 61064	Tiam H. Lie Rt. 5, Castellan, Dixon 61021
Livingston Members: 30-Dist. 2	Homer C. Parkhill 202 N. Main, Pontiac 61764	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
Logan Members: 26-Dist. 5	Steven D. Kottemann 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
Macon Members: 178-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Howard L. Wibbels 2300 N. Edward, Decatur 62526	H. Gale Zacheis 2220 N. Monroe, Decatur 62526
Macoupin Members: 18-Dist. 6	Dean Raft 217 W. Main St., Staunton 62088	Robert England 935 Morgan, Carlinville 62626
Madison Members: 219-Dist. 6	Thomas C. Hill #1 Lakewood IV, Edwardsville 62025	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion Members: 49-Dist. 7	Otto S. Espinosa 205 N. Davis St., Centralia 62801	W. P. Plassman 630 Short St., Centralia 62801
Marshall-Putnam Members: 4-Dist. 2	Donald M. Gallagher Box 538, Granville 61326	Joe W. Cannon, M.D., Secretary 202 South Main, Lacon 61540
Mason Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
Massac Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
McDonough Members: 32-Dist. 4	Wendell K. Stewart 301 E. Jefferson, Macomb 61455	Richard C. Watson 525 E. Grant, Macomb 61455
McHenry Members: 83-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Richard Gorski 715 W. Judd, Woodstock 60098	Daniel L. Vodovotz 1110 N. Green St., McHenry 60050

County	President	Secretary
McLean Members: 135-Dist. 5 Madge Williams, Exec. Sec. 1236 E. Empire Bloomington 61701	John L. Wright 2416 E. Washington St., Bloomington 61701	Jerry N. Ringer 1008 N. Main St., Bloomington 61701
Mercer Members: 5-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	Dennis D. Palmer 409 NW Fourth, Aldeo 61231
Monroe Members: 10-Dist. 10	Chung H. Khan 112 E. Fourth St., Waterloo 62298	Edilberto F. Maglasang 109 W. Legion, Columbia, 62236
Montgomery Members: 19-Dist. 5	Dennis Ross Billiter Med. Arts. Bldg., 1235 E. Union Litchfield 62056	Roger Wujek Medical Arts Building 1225 E. Union, Litchfield 62056
Morgan-Scott Members: 45-Dist. 6	Raymond E. Major 800 W. State, Jacksonville 62650	John Peterson 400 Farmers Bank Building, Jacksonville 62650
Moultrie Members: 5-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
Ogle Members: 18-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron Road, Rochelle 61068
Peoria Members: 447-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st National Bank Bldg. Peoria 61602	Lorin D. Whittaker, Jr. 214 N.E. Glen Oak, Peoria 61603	Thomas G. Cassidy 515 N.E. Glen Oak, Peoria 61603
Perry Members: 14-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
Piatt Members: 5-Dist. 7	George Green 1111 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike Members: 9-Dist. 6	Shehnaz Ansari 623 W. Washington, Pittsfield 62363	Carlos B. Lara 203 N. Madison, PO Box 328, Pittsfield 62363
Pulaski Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
Randolph Members: 23-Dist. 10	Orlan W. Pflasterer Coulterville 62237	J. M. Whittenberg 1650 State St., Chester 62233
Richland Members: 25-Dist. 8	Richard O. Peach Richland Mem. Hosp., Olney 62450	Chandri Varadachari Richland Memorial Hosp., Olney 62450
Rock Island Members: 205-Dist. 4 James A. Koch, Ex. Sec. 608 Kahl Bldg. 326 W. Third St. Davenport, Iowa 52801	Ralph D. Ade 550 30th Ave., Moline 61265	Philip T. Siegert 1504 7th St., Moline 61265
St. Clair Members: 283-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main, Suite 3L Belleville 62223	Michael G. Murphy 6401 W. Main, Belleville 62223	Harold S. Harsin 115 W. Randle, Lebanon 62254
Saline-Pope-Hardin Members: 28-Dist. 9	Charles Seten 203 N. Vine, Harrisburg 62946	Allen G. Gerberding Prof. Arts Bldg., U.S. Rte. 45 South, Harrisburg 62946
Sangamon Members: 423-Dist. 5 L. R. Brosi, Ex. Dir. 522 E. Monroe, Room 203 Springfield 62701	William W. Curtis 100 W. Miller St., Springfield 62702	Elvin G. Zook SIU School of Medicine, PO Box 3926, Springfield 62708

County	President	Secretary
Schuyler Members: 3-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby Members: 9-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson Members: 56-Dist. 12	Ahmed Rasheed 1036 W. Stephenson, Freeport 61032	Richard L. Rice 750 Kiwanis Dr., Freeport 61032
Tazewell Members: 69-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Wayne M. Keiserman PO Box 778, Pekin 61554	Terry O. Tosi P.O. Box 778, Pekin 61554
Union Members: 11-Dist. 9	Thomas W. Davis 319 S. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Main St., Anna 62906
Vermilion Members: 113-Dist. 8	Brijnandan F. Sodhi 735 N. Logan, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
Wabash Members: 6-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren Members: 15-Dist. 4	James W. Marshall 319 N. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington Members: 6-Dist. 10	Mcthee Vanadilok 111 S. Washington, Nashville 62263	Gary A. Goforth 113 W. St. Louis, Nashville 62263
Wayne Members: 10-Dist. 9	Sigmund W. Konarski 101 E. Center Rd., Fairfield 62837	Eugene B. Loftin 301 N.W. Eleventh St., Fairfield 62837
White Members: 6-Dist. 9	Morris A. McCall R.R. 2, Box 132 B, Carmi 62821	Morris A. McCall R.R. 2, Box 132 B, Carmi 62821
Whiteside Members: 53-Dist. 12	Shashi A. Patel 603 First Ave., #206, Sterling 61081	Thomas S. Vinje 101 E. Miller Rd., Sterling 61081
Will-Grundy Members: 268-Dist. 2 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Leo A. Wrona 2415 W. Jefferson, Joliet 60435	Theodore Dastych Joliet Medical Group, 2100 Glenwood, Joliet 60435
Williamson Members: 38-Dist. 9	Timoteo Castro 120 W. Walnut, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago Members: 408-Dist. 12 Robert Carlson Exec. Adm. 630 E. Jefferson Rockford 61107	Robert H. Harner 3271 Montlake Dr., Rockford 61111	Jovenel Dubois 5670 E. State St., Rockford 61108
Woodford Members: 6-Dist. 2	Victor V. Jay 601 N. Jefferson, Washburn 61570	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society: Cass-Brown, Edwards, Johnson, Menard
Joint County Societies: Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will-Grundy.

ISMS HOUSE OF DELEGATES

OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

Officers of ISMS

President—Robert P. Johnson
3000 Bennington, Springfield 62704
President-Elect—Robert C. Hamilton
711 W. North Ave., Chicago 60610
Secretary-Treasurer—Jere E. Freidheim
3050 S. Wallace, Chicago 60616
First Vice President—Ronald G. Welch
333 S. Illinois, Belleville 62220
Second Vice President—Alfred J. Clementi
675 W. Central Rd., Arlington Heights 60005
Speaker of the House—Julian W. Buser
6600 W. Main St., Belleville 62223
Vice Speaker of the House—Lawrence L. Hirsch
2434 Grace, Chicago 60618

Board of Trustees

Chairman, Board of Trustees—Warren D. Tuttle
203 N. Vine, Harrisburg 62946
1st District—John J. Ring
511 E. Hawley, Mundelein 60060 1984
2nd District—Allan L. Goslin
712 N. Bloomington, Streator 61364 1986
3rd District—James H. Andersen
141 Breakenridge Farm, Oak Brook 60521 1986
Richard H. Blankshain
715 Lake St., Oak Park 60301 1985
Audley F. Connor, Jr.
7531 Stony Island Ave., Chicago 60649 1986
Morris T. Friedell
7531 Stony Island, Chicago 60649 1984
Henrietta Herbolsheimer
1700 E. 56th Street, Chicago 60637 1984
Harold L. Jensen
3235 Vollmer Road, Flossmoor 60422 1986
Arthur R. Peterson
2740 W. Foster, Chicago 60625 1984
Pedro A. Poma
1200 Superior, Suite 402, Melrose Park 60160 1986
Clifton L. Reeder
516 Sheridan Road, Wilmette 60091 1984
Harry A. Springer
800 Austin Avenue, Suite 610, Evanston 60202 1986
4th District—George H. Burke
Rock Island Franciscan Hospital,
2701 17th St., Rock Island 61201 1985
5th District—Robert L. Prentice
2248 Warson Rd., Springfield 62704 1985
6th District—Robert R. Hartman
1040 College, Jacksonville 62650 1984
7th District—Alfred J. Kiessel
One Powers Lane Place, Decatur 62522 1985
8th District—Arthur R. Traugott
602 W. University, Urbana 61801 1985
9th District—Warren D. Tuttle
203 N. Vine, Harrisburg 62946 1984
10th District—Thomas P. Meirink
8601 W. Main St., Belleville 62223 1984
11th District—Raymond A. Dieter, Jr.
454 Pennsylvania, Glen Ellyn 60137 1986
12th District—Raymond E. Hoffmann
1030 Highview Ave., Rockford 61107 1986
Trustee-At-Large—Cyril C. Wiggishoff
2800 N. Sheridan Rd., Suite 602, Chicago 60657 1984
AMA Delegation Chairman, *Ex Officio*—
Howard C. Burkhead, 130 Dempster St.,
Evanston 60202
ISMIE Board of Governors Chairman, *Ex Officio*—
Fred Z. White, P.O. Box 279, 525 Sweetbriar,
Chillicothe 61523

Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House appears on page 297.

EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

Past Presidents

J. Ernest Breed* 1971
Herschell Browns* 1981
Edward W. Cannady* 1970
Newton DuPuy* 1968
David S. Fox* 1979
H. Close Hesseltine* 1961
J. M. Ingalls 1976
Charles J. Jannings, III 1972
Frank J. Jirka, Jr.* 1973
Fredric D. Lake* 1975
Burtis E. Montgomery* 1966
Caesar Portes* 1967
Jacob E. Reisch (Honorary)* 1979
Willard C. Scrivner* 1974
P. John Seward* 1980
Joseph H. Skom* 1977
Leo P. A. Sweeney* 1953
Philip G. Thomsen* 1969
Fred Z. White* 1982
Cyril C. Wiggishoff* 1983
George T. Wilkins, Jr. 1978
*Also a past trustee or councilor

Past Speakers

Walter C. Bornemeier, Chicago 1962-1964
Edward W. Cannady, Belleville 1965-1967
Maurice M. Hoeltgen, Chicago 1968-1970
Paul W. Sunderland, Gibson City 1971-1973
Andrew J. Brislen, Chicago 1974-1975
James A. McDonald, Geneva 1975-1977
Cyril C. Wiggishoff, Chicago 1977-1979
Robert P. Johnson, Springfield 1979-1981
Clifton L. Reeder, Wilmette 1981-1983

EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

Past Trustees

Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Julian W. Buser
Belleville, Trustee of the 10th District
Raymond DesRosiers
Chicago, Trustee of the 3rd District
Herbert Dexheimer
Belleville, Trustee of the 10th District
Alfred Faber
Northbrook, Trustee of the 3rd District
Robert T. Fox
Chicago, Trustee of the 3rd District
Jere Freidheim
Chicago, Trustee of the 3rd District
Lee N. Hamm
Lincoln, Trustee of the 5th District
Eugene Hoban
Chicago, Trustee of the 3rd District
Kenneth Hurst
Naperville, Trustee of the 11th District
Ross Hutchison
Gibson City, Trustee of the 11th District
Eugene P. Johnson
Casey, Trustee of the 8th District
James Laidlaw
Champaign, Trustee of the 8th District
Harold J. Lasky
Chicago, Trustee of the 3rd District
Ted LeBoy
Chicago, Trustee of the 3rd District
A. Edward Livingston
Bloomington, Trustee of the 5th District
Paul F. Mahon
Springfield, Trustee of the 5th District
Joseph R. O'Donnell
Glen Ellyn, Trustee of the 11th District
Joseph Perez
Rockford, Trustee of the 12th District
Mather Pfeiffenberger
Alton, Trustee of the 6th District
Ralph N. Redmond
Sterling, Trustee of the 2nd District
Richard H. Rovner
Chicago, Trustee of the 3rd District
Joseph C. Sherriek
Chicago, Trustee of the 3rd District
George Shropshear
Chicago, Trustee of the 3rd District
Darrell H. Trumpe
Springfield, Trustee of the 5th District
Frederick E. Weiss
Harvey, Trustee of the 3rd District
Charles K. Wells
Mt. Vernon, Trustee of the 9th District
Herman Wing
Chicago, Trustee of the 3rd District
Warren W. Young
Chicago, Trustee of the 3rd District

ISMS DELEGATION TO THE AMA

Delegation Chairman: Howard C. Burkhead; Secretary: Morgan M. Meyer

Delegates

To serve from Jan. 1, 1982 to Dec. 31, 1983
(Elected April 7, 1981)

Herschel Browns, Chicago
Howard Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Maynard I. Shapiro, Chicago
Joseph Skom, Chicago
Cyril C. Wiggishoff, Chicago

To serve from Jan. 1, 1983 to Dec. 31, 1984
(Elected April 17, 1982)

David S. Fox, Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Chicago
Michael Nieder, Chicago*
Joseph R. O'Donnell, Glen Ellyn
John J. Ring, Mundelein
P. John Seward, Rockford
George T. Wilkins, Granite City

To serve from Jan. 1, 1984 to Dec. 31, 1985
(Elected April 24, 1983)

Howard C. Burkhead, Evanston
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Morgan M. Meyer, Lombard
Joseph H. Skom, Chicago
Arthur Traugott, Urbana
Cyril C. Wiggishoff, Chicago

Alternates

To serve from Jan. 1, 1982 to Dec. 31, 1983
(Elected April 7, 1981)

Alfred Clementi, Arlington Heights
Allan Goslin, Streator
Robert C. Hamilton, Chicago
Harold Jensen, Chicago**
A. Beaumont Johnson, Elgin
Harold Lasky, Chicago
Arthur Traugott, Urbana
Ronald Weleh, Belleville
Fred Z. White, Chillicothe

To serve from Jan. 1, 1983 to Dec. 31, 1984
(Elected April 17, 1982)

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
James DeBord, Peoria***
Robert P. Johnson, Springfield
Alfred J. Kiessel, Decatur
Joseph Perez, Peoria
Clifton L. Reeder, Wilmette
Harry Springer, Chicago
Richard Terek, Chicago*

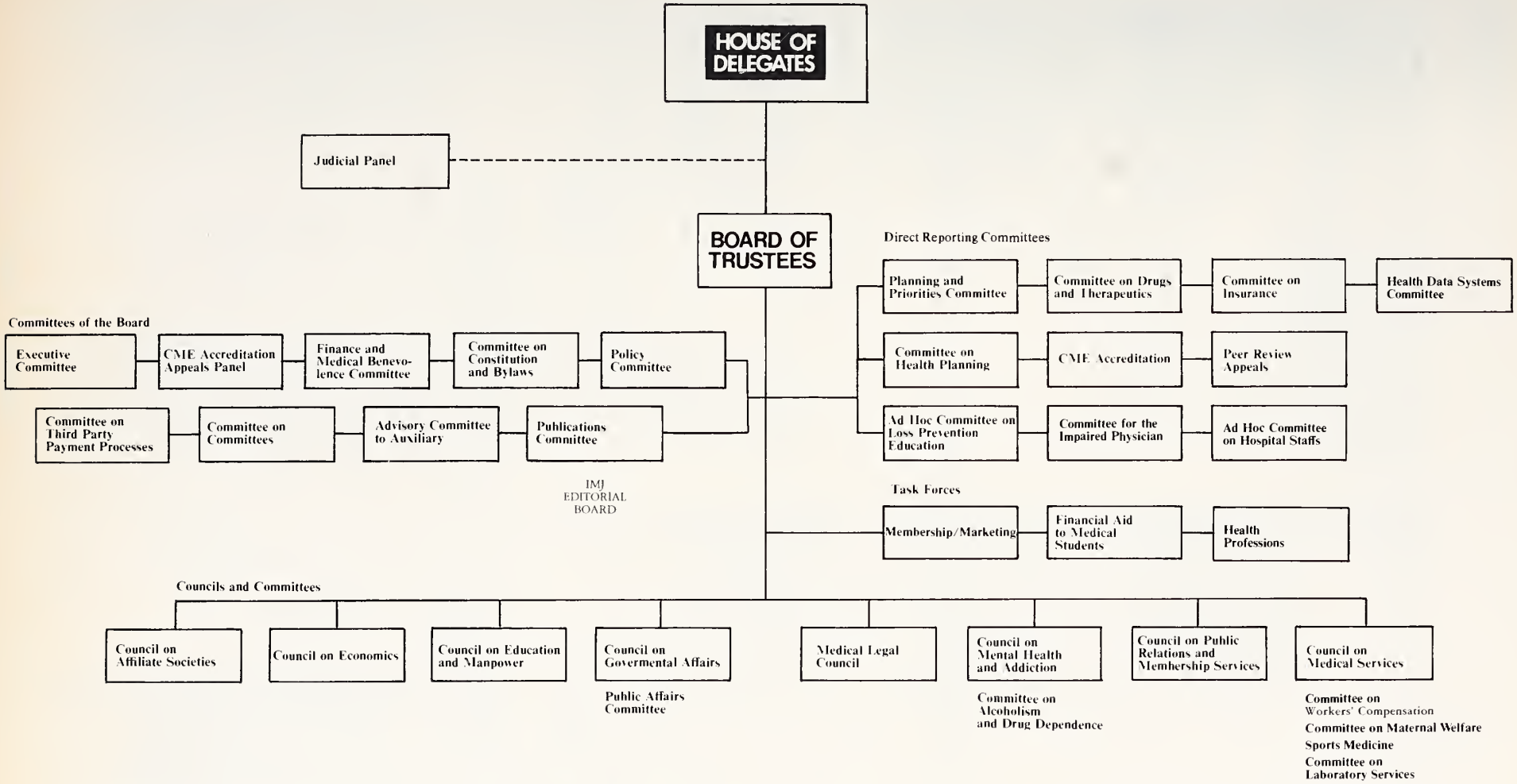
To serve from Jan. 1, 1984 to Dec. 31, 1985
(Elected April 24, 1983)

Randall T. Bellows, Chicago
Jere Freidheim, Chicago
Allan Goslin, Streator
Harold Jensen, Flossmoor
A. Beaumont Johnson, Elgin
Pedro A. Poma, Melrose Park
Warren D. Tuttle, Harrisburg
Ronald Weleh, Belleville
Fred Z. White, Chillicothe

**Elected April 24, 1983 to seventeenth position*
***Appointed April 24, 1983 to fill unexpired term until Dec. 31, 1983*
****Elected April 24, 1983 to complete unexpired term beginning Jan. 1, 1984*

Honorary Members

Walter C. Bornemeier, Saratoga, California; Frank J. Jirka, Jr., Barrington Hills; Burtis E. Montgomery, New York



Organizations Directly Related to ISMS

- Illinois Foundation for Medical Care
- Illinois Council on Continuing Medical Education
- Illinois State Medical Benevolent Fund, Inc.
- Illinois State Medical Insurance Services, Inc.
- Illinois State Medical Inter-Insurance Exchange
- ISMS Educational and Scientific Foundation
- Medical Student Section
- Resident Physician Section

Organizations with formal ISMS Representation

- Swanberg Foundation
- Ill. Society, American Association of Medical Assistants
- Ill. Interagency Council on Smoking and Disease
- M.D. Committee on Optometry
- The Commission on Children
- INA/ISMS Joint Practice Comm.
- Ill. Medical Records Assn.
- Illinois Cancer Council
- IMPAC
- Citizen's Committee on an Illinois Program to Control High Blood Pressure
- U. S. Pharmacopaeia
- Ill. Migrant Council
- Student Loan Fund Board, ISMS/IAA

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, Speaker of the House, and Chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

COUNCIL ON AFFILIATE SOCIETIES

Raymond A. Dieter, Jr., Glen Ellyn, *Chairman*
Illinois Thoracic Surgical Society
Jerome S. Beigler, Chicago
Illinois Psychiatric Society
Robert Borkenhagen, Indian Head Park
Chicago Laryngological & Otological Society
Raymond L. Del Fava, Evanston
Illinois Radiological Society
Patrick W. Elwood, Peoria
Illinois Neurological Society
Anthony G. Finder, Chicago
Illinois Association of Ophthalmology
Malachi Flanagan, Chicago
Ill. State Urological Society
Gustav Giebelhausen, Peoria
Ill. Chapter, American College of Surgeons
William Gottschalk, Chicago
Illinois Society of Anesthesiologists, Inc.
Donald H. Hanscom, Hinsdale
Illinois Society of Internal Medicine
Donald R. Ingram, Alton
Illinois Society of Ophthalmology and Otolaryngology
William J. Kane, Chicago
Illinois Orthopaedic Society
Theodore M. Kanellakes, Joliet
Allergy & Clinical Immun. Society of IL
John McLaughlin, Jr., Joliet
Ill. Sect., American College of OB-GYN
Robert C. Muehrcke, Oak Park
Ill. Chapter, American College of Physicians
David H. Paul, Belleville
Ill. Chapter, American College of Emergency Physicians
Milton Robin, Chicago
Illinois Dermatological Society
Stanley S. Smith, Urbana
Illinois OB-GYN Society
Robert Swastek, Chicago
Ill. Chapter, American Academy of Family Physicians

Other Organizations Represented
Illinois Society of Pathologists
Illinois Chapter, American Academy of Pediatrics
Illinois Surgical Society

Consultants:
Jere E. Freidheim, Burr Ridge
Raymond E. Hoffmann, Rockford

Responsibilities and Purposes:

To improve communications and provide liaison with the specialty societies; provide specialty consultations to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

COUNCIL ON ECONOMICS

Fred Z. White, Chillicothe, *Chairman*
Lorris M. Bowers, Peoria
James R. DeBord, Peoria
Bernard J. Feldman, Chicago
Edward Ference, Springfield
Theodore Grevas, Rock Island
A. Beaumont Johnson, Elgin
Joseph M. Purpura, Lake Forest
Robert C. Wanless, Belleville

Consultants:
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville

Student
Thomas Zusag, Chicago

Resident
Charles Cattano, Chicago

Responsibilities and Purposes:

The Council on Economics considers issues regarding the costs, delivery and utilization of health care services. The council is interested in effective practice management and the economic impact of both government health policies and new health care delivery systems. The Council examines the impact of proposed new delivery systems and reports its recommendations to the Board.

COUNCIL ON EDUCATION AND MANPOWER

Boyd McCracken, Sr., Greenville, *Chairman*
David Bristow, Effingham
Earl Fredrick, Olympia Fields
Mack Hollowell, Charleston
Ronald Johnson, Pleasant Hill
Eugene B. Loftin, Fairfield
Steven Macke, Marshall
Albert Maurer, Hopedale
Aldo F. Pedroso, Skokie
Alan M. Roman, Flossmoor
David Spindel, Chicago
Natalie Stephens, Chicago

Resident Representative

John Diveris, Chicago

Student Representative

Paula M. Olen-Mikrut, Brookfield

IMGMA Representative

Steven R. Perrigo, Springfield

Consultants

Lawrence L. Hirsch, Chicago
Pedro A. Poma, Melrose Park
Robert L. Prentice, Springfield
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to edueation.

GOVERNMENTAL AFFAIRS COUNCIL

James Laidlaw, Champaign, *Chairman*
Lawrence Breslow, Glencoe
David S. Fox, Chicago
Jerome Frankel, Evanston
William Gottschalk, Winnetka
Henri Havdala, Chicago
William F. Hays, Herrin
Paul Mahon, Springfield
George T. Mitehell, Marshall
Tassos Nassos, Northbrook
John Ovitz, Sycamore
Edward Ragsdale, Alton
Jerry Ramunis, Galesburg
P. John Seward, Loves Park
Herbert Sohn, Chicago
Alex Spadoni, Joliet
Stephen Stone, Springfield

Auxiliary Representative

Mrs. Alan Taylor, Danville

Student Representative

Richard Terek, Chicago

Resident Representative

Ronald Davis, Highland, Indiana

Consultants

Howard Burkhead, Evanston
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Ronald Welch, Belleville
Cyril C. Wiggishoff, Chicago

Illinois Medical Group Management Association Representative

Dennis Mock

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs

PUBLIC AFFAIRS COMMITTEE

Herbert Sohn, Chicago, *Chairman*
Eugene Branovacki, Chicago
Louis Dondanville, Molinc
Edwin Falloon, Palos Heights
Delbert H. Hahn, Decatur
Don E. Hinderliter, Rochelle
Frank J. Jirka, Jr., Barrington Hills
Sandra J. Olson, Chicago
Albert W. Ray, Jr., Joliet
Richard Schenk, Urbana
Willard C. Scrivner, Belleville
Patrick Staunton, Park Ridge
A. E. Steer, Springfield
Mrs. Alan Taylor, Danville
George T. Wilkins, Edwardsville

IMGMA Representative

Patrick Quigley, Springfield

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

Donal D. O'Sullivan, Oak Park, *Chairman*
Geoffrey Bland, Springfield
Robert Eilers, Evanston
Saul Haskell, Chicago
Herbert Henkel, Springfield
James Hull, Belleville
Robert Libman, Chicago
Hugo R. Velarde, Chicago
Michael Victor, Barrington
Harold Walgren, Downers Grove

Consultants

James H. Andersen, Oak Brook
Robert C. Hamilton, Chicago
Thomas Meirink, Belleville

Resident Representative

Thomas Mizen, Chicago

Student Representative

Gail Williamson, Chicago

Responsibilities and Purposes:

The Council shall cooperate with all organizations interested in medico-legal problems and educate members of the profession in such affairs. In addition, the council shall be concerned with standards of practice, licensure and quackery.

This council shall maintain liaison with the Illinois State Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel and the Worker's Compensation Roster. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

COUNCIL ON MEDICAL SERVICES

Joseph D. Winterhalter, Jacksonville, *Chairman*
Wallace Berkowitz, Belleville
Serge Eytan, Chicago
C. Larkin Flanagan, Chicago
Adarsh Kumar, Springfield
Meredith Murray, Oak Park
H. Bates Noble, Chicago
Daniel J. Pachman, Chicago
Donald F. Pochyly, Hines
Forrest H. Riordan, III, Rockford
Alan Stein, Alton
Kenneth M. Uznanski, Joliet
Benjamin Williams, Urbana

Consultants:

Henrietta Herbolsheimer, Chicago
Raymond E. Hoffmann, Rockford

Auxiliary Representative

Mrs. Selig Hodes, Forreston

Student Representative

Michael Brottman, Skokie

Resident Representative

Peter Panton, Chicago

Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, laboratory services and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workers' compensation, and the penal health care services.

Committees:

Laboratory Services
Maternal Welfare
Sports Medicine
Workers' Compensation

COMMITTEE ON LABORATORY SERVICES

Benjamin Williams, Urbana, *Chairman*
Allan C. Campbell, Peoria
John Dietrich, Springfield
Thomas Harwood, Chicago
John Mason, Oak Lawn
Richard Sassetti, Chicago
Marshall Short, Chicago
Peter Soto, Belleville
Earl Suckow, Mt. Prospect
Antoinette Thomas, Carbondale

Consultant:

Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COMMITTEE ON MATERNAL WELFARE

District Members and Alternates
(alternates in italics)

1. Joseph Burke, Waukegan
2. Kenneth M. Uznanski, Joliet, *Chairman*
Carl P. Mattioda, Streator
3. Marvin A. Rosner, Chicago
Warren H. Staley, Chicago
4. Raoul E. Reinertsen, Canton
Robert Westerfer, Peoria
5. William H. Schultz, Springfield
Kofi S. Amankwah, Springfield
6. Richmond H. Simmons, Jacksonville
Richard D. Yoder, Alton
7. Herbert W. Thompson, Decatur
William L. Wagner, Decatur
8. Lewis Trupin, Champaign
Larry R. Lane, Champaign
9. William B. Skaggs, Harrisburg
Roger N. Klam, Carbondale
10. Stephen V. Mueller, Belleville
Casimiro Garcia, Jr., Belleville
11. A. William Schafer, Hinsdale
Thomas R. Eckman, Downers Grove
12. John E. Tillis, Rockford
Gordon T. Burns, Rockford

Consultants:

William Gottschalk, Winnetka
Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Augusta Webster, Chicago

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

SPORTS MEDICINE COMMITTEE

H. Bates Noble, Chicago, *Chairman*
Henry Dold, Arlington Heights
Clarence Fossier, Lake Forest
James L. Green, Jacksonville
Ed Grogg, Urbana
James A. Hill, Chicago
Joseph Hinkamp, Glenview
J. M. Ingalls, Paris
William T. Sheehy, Elgin
Howard J. Sweeney, Evanston

Consultants:

Audley F. Connor, Jr., Chicago
Robert C. Hamilton, Chicago

Auxiliary Representative

Mrs. Harold Keegan, Kankakee

Responsibilities and Purposes:

The committee conducts programs aimed at improving the recognition and treatment of athletic-related injury and disease; provides educational material to junior and senior high school coaches and trainers; and works with other groups and organizations involved in sports medicine activities.

COMMITTEE ON WORKERS' COMPENSATION

Forrest H. Riordan, III, Rockford, *Chairman*
Ernest Adams, Peoria
Richard Blonsky, Chicago
Milton R. Carlson, Champaign
Richard Geline, Skokie
Alvin Palow, Kankakee
James R. Ryan, DesPlaines
Michael R. Treister, Chicago

Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the workers' compensation system in Illinois.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Leroy Levitt, Chicago, *Chairman*
Richard Banta, Rockford
S. Dale Loomis, Chicago
Silvana Menendez, Belleville
Thomas Minogue, Urbana
Garth Smith, Hinsdale
Earl Solon, DesPlaines
Robert Study, Chicago
Kishore Thampy, Chicago

CONSULTANTS:

James H. Andersen, Oak Brook
Allan L. Goslin, Streator
Arthur R. Traugott, Urbana

AUXILIARY REPRESENTATIVE

Mrs. Alex Spadoni, Hinsdale

STUDENT REPRESENTATIVE

Gail Herman, Chicago

RESIDENT REPRESENTATIVE

Frank Pieri, Chicago

IDMHDD REPRESENTATIVE

John Nelson, Elgin

Responsibilities and Purposes:

This council serves as a source of information on mental health matters for ISMS, evaluates information and makes recommendations to the Board of Trustees on positions the Society should take on issues in this area and cooperates with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse. It is also concerned with reviewing legislation and regulations related to the fields of mental health, alcoholism, drug abuse and controlled substances.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Richard Banta, Rockford, *Chairman*
H. Constance Bonbrest, Chicago
Andrew Griffin, Maywood
Donald Sellers, DesPlaines
Peter Talso, Chicago
Ruth Wharton, River Forest

CONSULTANTS:

J. Roalda Alderman, Div. of Alcoholism, Chicago
Donald Behnke, DDC, Chicago

AUXILIARY REPRESENTATIVE

Lynn Kassel, Joliet

IMGMA REPRESENTATIVE

Barbara Birnbaum, Chicago

Responsibilities and Purposes:

The committee works closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Leo Wrona, Joliet, *Chairman*
James Bauer, Peoria
Brad L. Epstein, Chicago
Reuben Ramkissoon, Hinsdale
David A. Rothstein, Chicago

CONSULTANTS:

James H. Andersen, Oak Brook
Clifton L. Reeder, Wilmette
Harry A. Springer, Evanston

STUDENT REPRESENTATIVE

Steven Kmucha, Chicago

AUXILIARY REPRESENTATIVE

Mrs. Robert Reardon, Bloomington

RESIDENT REPRESENTATIVE

Joseph DiBeneditto, Oak Park

IMGMA REPRESENTATIVE

John Robertson, Springfield

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socioeconomic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

Cyril C. Wiggishoff, Chicago, *Chairman*
Robert P. Johnson, Springfield
Warren D. Tuttle, Harrisburg

Responsibilities and Purposes:

The committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members. It shall also monitor the services provided by ISMS to the Auxiliary.

COMMITTEE ON COMMITTEES

Allan L. Goslin, Streator, *Chairman*
Raymond E. Hoffmann, Rockford
Harold L. Jensen, Flossmoor
Harry A. Springer, Evanston

Responsibilities and Purposes:

The Committee on Committees shall consist of members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION AND BYLAWS

Clifton L. Reeder, Wilmette, *Chairman*
Julian W. Buser, Belleville
Robert R. Hartman, Jacksonville
Lawrence L. Hirsch, Chicago
Thomas P. Meirink, Belleville

Responsibilities and Purposes:

The Committee on Constitution and Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

CME ACCREDITATION APPEALS PANEL

Richard H. Blankshain, Oak Park
Morris T. Friedell, Chicago
Robert C. Hamilton, Chicago
Henrietta Herbolsheimer, Chicago
Pedro A. Poma, Melrose Park
Ronald G. Welch, Belleville
Fred Z. White, Chillicothe

Responsibilities and Purposes:

In the event the Committee on CME Accreditation makes a non-accreditation decision to an Illinois CME sponsor, the sponsor may make a formal appeal to this hearing committee, which, in turn, will make a formal recommendation to the ISMS Board of Trustees on the sponsor's application.

POLICY COMMITTEE

Richard H. Blankshain, Oak Park, *Chairman*
James H. Andersen, Oak Brook
John J. Ring, Mundelein

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

EXECUTIVE COMMITTEE

Warren D. Tuttle, Harrisburg, *Chairman*
Jere E. Freidheim, Chicago
Morris T. Friedell, Chicago
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Alfred J. Kiessel, Decatur
Ronald G. Welch, Belleville
Cyril C. Wiggishoff, Chicago

Ex Officio (without vote)

Howard C. Burkhead, Evanston
Julian W. Buser, Belleville
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, the chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Alfred J. Kiessel, Decatur, *Chairman*
George H. Burke, Rock Island
Audley F. Connor, Jr., Chicago
Jere E. Freidheim, Chicago

Auxiliary Representative
Mrs. Louis Tarsinos

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the Society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

PUBLICATIONS COMMITTEE

Henrietta Herbolsheimer, Chicago, *Chairman*
Raymond A. Dieter, Jr., Glen Ellyn
Pedro A. Poma, Oak Brook
John J. Ring, Mundelein
Harry A. Springer, Evanston

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, shall review all new accounts prior to acceptance and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*
Eli L. Borkon, Carbondale
Joseph R. Christian, Chicago
Ediz Z. Ezdinli, Kenilworth
Eugene J. Rogers, Chicago
Constantine S. Soter, Northbrook
David E. Trachtenbarg, Peoria
Donald D. VanFossan, Springfield

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Arthur R. Traugott, Urbana, *Chairman*
Alfred J. Clementi, Arlington Heights
George H. Burke, Rock Island
Allan L. Goslin, Streator
Arthur R. Peterson, Chicago
Robert L. Prentice, Springfield
Ronald G. Welch, Belleville
Cyril C. Wiggishoff, Chicago

Ill. Medical Group Mngmt. Assoc. Reps.

Nancy Koch, Chicago

Responsibilities and Purposes:

The Committee on Third Party Payment Processes is a committee of the Board of Trustees. Its responsibility primarily is dealing with appropriate governmental and private entities on matters of direct and immediate economic concern to the practice of medicine. It monitors the activities of the Illinois Medicare program, the Illinois Department of Public Aid, the Illinois CHAMPUS program, Blue Cross/Blue Shield, other private insurers and corporations, and other appropriate entities (*e.g.,* Foundations for Medical Care, etc.) which have a significant economic impact upon medicine. This Committee negotiates under the direction of the Board of Trustees to affect appropriate changes in economic programs and regularly reports to the Board of Trustees on its progress.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Robert A. Behmer, Rockford, *Chairman*
Terry F. Hatch, Urbana
Walter F. Kondratowicz, Chicago
Joseph P. McKay, Elmhurst
Birendra K. Sinha, Elk Grove Village
Dennis J. Stanczyk, Belleville
Simon Zivin, Chicago

Consultant:

Harold L. Jensen, Flossmoor

Responsibilities and Purposes:

Adopt necessary procedural rules and prescribe forms to be used in the conduct of CME accreditation, within prescribed policies. Review sponsor applications and survey team reports for intrastate CME sponsors, and make decision on grant of initial accreditation and continuation of accredited status.

ILLINOIS CME SPONSORS ACCREDITED FOR CONTINUING MEDICAL EDUCATION AS OF SEPTEMBER 30, 1983

Alexian Brothers Medical Center—Elk Grove Village
Augustana Hospital—Chicago
Belleville Hospital Association for CME
(Memorial Hospital, St. Elizabeth Hospital)
Carle Foundation Hospital—Urbana
Central Community Hospital—Chicago
Central DuPage Hospital—Winfield
Chicago Center Hospital
Chicago College of Osteopathic Medicine
Chicago Medical Society
Christ Hospital—Oak Lawn
Columbus-Cuneo-Cabrini Medical Center—Chicago
Community General Hospital—Sterling
Condell Memorial Hospital, Libertyville
Copley-Mercy CME Consortium—Aurora
DuPage County Medical Society
Edgewater Hospital, Chicago
Elgin Mental Health Center
FAB³-CME, (Forkosh Memorial, Belmont Community, Bethesda, Bethany Methodist, Thorek Medical Center) Chicago
Forest Hospital—DesPlaines
Franciscan Medical Center—Rock Island
Glendale Heights Community Hospital
Good Samaritan Hospital—Downers Grove
Good Samaritan Hospital—Mt. Vernon
Gottlieb Memorial Hospital—Melrose Park
Grant Hospital of Chicago
Henry Horner Childrens' Center—Chicago
Highland Park Hospital
Hinsdale Sanitarium & Hospital
Holy Cross Hospital—Chicago
Humana Hospital, Hoffman Estates
Hyde Park Community Hospital, Chicago
Illinois Council on Continuing Medical Education
American Heart Assn. (Ill. Affiliate)
Illinois Masonic Medical Center—Chicago
Ingalls Memorial Hospital—Harvey
Institute for Psychoanalysis—Chicago
Jackson Park Hospital—Chicago
Kishwaukee Community Health Center—DeKalb
Lake Forest Hospital

Loretto Hospital—Chicago
Louis A. Weiss Memorial Hospital—Chicago
Loyola University Stritch School of Medicine—Maywood
Lutheran General Hospital—Park Ridge
Lutheran Hospital—Moline
MacNeal Memorial Hospital—Berwyn
Martha Washington Hospital—Chicago
Mary Thompson Hospital—Chicago
Memorial Hospital of DuPage County—Elmhurst
Mercy Hospital & Medical Center—Chicago
The Methodist Medical Center of Illinois—Peoria
Mount Sinai Hospital Medical Center of Chicago
Northwestern University Medical School—Chicago
North Shore Mental Health Association/Irene Josselyn Clinic—Northfield
Northwest Hospital—Chicago
Northwest Community Hospital—Arlington Heights
Norwegian-American Hospital—Chicago
Oak Forest Hospital
Oak Park Hospital
Provident Hospital—Chicago
Ravenswood Hospital Medical Center—Chicago
Resurrection Hospital—Chicago
Riveredge Hospital—Forest Park
Riverside Hospital—Kankakee
Rockford Memorial Hospital
Rush Medical College—Chicago
St. Anne's Hospital—Chicago
St. Anthony Hospital—Chicago
St. Anthony Hospital—Rockford
St. Elizabeth's Hospital—Chicago
St. Elizabeth Hospital—Danville
St. Francis Hospital—Blue Island
St. Francis Hospital—Evanston
St. Francis Hospital-Medical Center—Peoria
St. Joseph Hospital—Chicago
St. Joseph Hospital—Elgin
St. Mary's Hospital—Kankakee
St. Mary's Hospital—Streator
St. Mary of Nazareth Hospital—Chicago
St. Therese Hospital—Waukegan
Sarah Bush Lincoln Health Center—Mattoon
Sherman Hospital—Elgin
Shriner's Hospital for Crippled Children—Chicago
Silver Cross Hospital—Joliet
Skokie Valley Community Hospital—Skokie
South Chicago Community Hospital
Southern Illinois University School of Medicine—Springfield
Springfield Clinic
Swedish American Hospital—Rockford
Swedish Covenant Hospital—Chicago
University of Chicago Pritzker School of Medicine
University of Health Sciences/The Chicago Medical School
University of Illinois College of Medicine
Victory Memorial Hospital—Waukegan
Westlake Community Hospital—Melrose Park
West Suburban Hospital—Oak Park
Woodlawn Hospital—Chicago

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Chicago, *Chairman*
Amin N. Daghestani, Skokie
Ignacio DelValle, Taylorville
Dorothy Hubler, Casey
Martin J. Kaplan, Highland Park
Arthur Marks, Fairfield
Robert Reeder, St. Charles

CONSULTANTS:

A. Samuel Enloe, R.Ph., Decatur
Harold L. Jensen, Flossmoor
Kerrison Juniper, Springfield
Dawn Atkins-Gottrich, IDPA

Responsibilities and Purposes:

The committee shall meet periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Comments or suggestions made by the membership regarding drug products are reviewed by the committee.

HEALTH DATA SYSTEMS COMMITTEE

Audley F. Connor, Jr., Chicago, *Chairman*
Andrew Brislen, Chicago
Alexander Goldstein, Harrisburg
Allan Goslin, Streator
Henrietta Herbolsheimer, Chicago
Joseph R. O'Donnell, Glen Ellyn
Clifton L. Reeder, Wilmette
Walter Stevenson III, Quincy
Ben T. Williams, Urbana

CONSULTANT:

Alexander R. Lerner

Responsibilities and Purposes:

The committee shall maintain ongoing awareness of: (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the Committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees and other appropriate persons within ISMS advised on data collection matters.

COMMITTEE ON HEALTH PLANNING

Samuel L. Andelman, Skokie, *Chairman*
Ronald F. Albrecht, Chicago
Eli L. Borkon, Carbondale
Robert D. Dooley, Oak Brook
Norris R. Dougherty, Rockford
Gerald W. Grawey, Peoria
Robert M. Vanecko, Chicago

Consultants:

George H. Burke, Rock Island
Alfred J. Clementi, Arlington Heights
Raymond A. Dieter, Jr, Glen Ellyn
Henrietta Herbolsheimer, Chicago
Alfred J. Kiessel, Decatur

Auxiliary Representative

Suzanne Meirink, Belleville

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies. The Committee also monitors the health care coalition movement and reports to the Board on coalition activities.

AD HOC COMMITTEE ON HOSPITAL MEDICAL STAFFS

Cyril C. Wiggishoff, Chicago, *Chairman*
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
J.M. Ingalls, Paris
Robert P. Johnson, Springfield
John J. Ring, Mundelein
Warren D. Tuttle, Harrisburg

Responsibilities and Purposes:

The Ad Hoc Committee shall address the concerns and develop programs for ISMS members as physicians on hospital medical staffs in their association with the administration and governing boards of hospitals. The committee shall keep ISMS members abreast of developments in hospital-medical staff relationships; monitor and work with the AMA Hospital Medical Staff Section and ongoing efforts organized by component societies; and to the extent feasible, provide informal liason with organizations impacting on Illinois hospital medical staffs.

COMMITTEE FOR THE IMPAIRED PHYSICIAN

Lee Gladstone, Chicago, *Chairman*
Richard Banta, Rockford
Violet Eggert, Tinley Park
Kilian Fritsch, Belleville
Richard Lee, Peoria
LeRoy Levitt, Chicago
L. Michael Newman, Evanston
Albert S. Norris, Springfield
Homer Parkhill, Pontiac
Deming Payne, Hinsdale
Reinhold Schuller, Bourbonais
Donald Sellers, Des Plaines
Edward Senay, Chicago
Craig Showalter, Chicago
Jack Spicer, Decatur
W. David Steed, Oak Park
Peter Talso, Chicago
Herbert Trace, Evanston
William J. Weigel, Aurora

Responsibilities and Purposes:

The Committee for the Impaired Physician consists of physicians who counsel fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to physical disabilities, mental or emotional disturbances, in a confidential and professional manner. It provides information and conducts educational programs on dealing with impairment.

COMMITTEE ON INSURANCE

William Henry, Springfield, *Chairman*
Anne L. Barlow, N. Chicago
Stephen Burdon, Peoria
Herbert Epstein, Glencoe
Warren C. Jenkins, Northbrook

CONSULTANTS:
Richard H. Blankshain, Oak Park
Phillip Boren, Carmi
Gerald S. Modjeska, Chicago
Arthur Peterson, Chicago
Clifton L. Reeder, Wilmette

IMGMA REPRESENTATIVE
Gerald T. O'Brien, Chicago

Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the programs' administrator, Corroon & Black, Inc.

AD HOC COMMITTEE ON LOSS PREVENTION EDUCATION

Alfred J. Clementi, Arlington Heights, *Chairman*
Donald Aaronson, Chicago
Randall T. Bellows, Chicago
Phillip Boren, Carmi
Sara C. Charles, Chicago
Robert R. Hartman, Jacksonville
Donal D. O'Sullivan, Chicago
Clifton L. Reeder, Chicago
Richard Wilbur, Lake Forest

Responsibilities and Purposes:

The ad hoc Committee on Loss Prevention Education seeks to help physicians identify legal dicta and court procedures and the application of these to medical practice. It seeks to enable physician identification of potential problems in various medical procedures and practice settings and effect a change in same. Educational efforts are intended to improve the quality of medical care and prevent law suits.

PEER REVIEW APPEALS COMMITTEE

George J. Gertz, Chicago, *Chairman*
Boone Brackett, Oak Park
Eugene T. Hoban, Oak Park
Carl Johnson, Moline
Harry L. Lewis, Benton
Anne Marie Shute, Highland Park
Lloyd E. Thompson, East St. Louis

Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relations issues. The committee is the state Society's liaison to local peer review committees and monitors review activities around the state.

PLANNING AND PRIORITIES COMMITTEE

Robert C. Hamilton, Chicago, *Chairman*
Randall T. Bellows, Chicago
Albert G. Bledig, Eldorado
Michael G. Murphy, Belleville
Harry A. Springer, Evanston
Lorin D. Whittaker, Jr., Peoria

Responsibilities and Purposes:

The President-Elect shall serve as the chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, Chillicothe, *Chairman*
Julian W. Buser, Belleville
Robert P. Johnson, Springfield
Malcolm Major, Chicago
Cyril C. Wiggishoff, Chicago

Auxiliary Representative
Diane Hinderliter, Rochelle

Responsibilities and Purposes:

The Task Force on Financial Aid to Medical Students shall be responsible for developing and maintaining a student loan program through the Educational & Scientific Foundation to assist Illinois medical students in meeting financial obligations of an undergraduate medical school program. In particular, this Task Force shall explore ways and means of raising funds for the development of a student loan program and, through the ISMS Educational and Scientific Foundation, establish guidelines and administration for such a program.

TASK FORCE ON HEALTH PROFESSIONS

Allan Goslin, Streator, *Chairman*
Herbert Allen, Chicago
Joseph Perez, Rockford
Pedro Poma, Melrose Park

Responsibilities and Purposes:

The Task Force on Health Professions shall be responsible for providing a discussion forum for common issues affecting physicians and representatives of health professions who work under close physician supervision in the day to day care of patients. This Task Force shall monitor credentialing and licensure of such professionals by the State of Illinois. It shall also consider conducting symposia on health professions.

TASK FORCE ON MEMBERSHIP/MARKETING

Robert C. Hamilton, M.D., Chicago, *Chairman*
Linda Brubaker, Chicago
Student Representative
Brad Epstein, M.D., Chicago
Resident Representative
John Hanni, Peoria
Exec., Peoria Med. Soc.
Robert P. Johnson, M.D., Springfield
Clifton Reeder, M.D., Wilmette
Fred Schwartz, Chicago
Exec., Chicago Med. Soc.
Ronald Welch, M.D., Belleville
Lillian Widmer, Glen Ellyn
Exec., DuPage County Med. Soc.
Cyril C. Wiggishoff, M.D., Chicago
Madge Williams, Bloomington
Exec., McLean County Med. Soc.

Responsibilities and Purposes:

The Task Force on Membership/Marketing shall work to (1) retain current ISMS members and recruit new ISMS members; (2) build future membership through residents and medical student members; (3) coordinate with county medical societies retention and recruitment of mutual members; (4) cooperate with the American Medical Association to retain and recruit mutual members and (5) enhance membership in organized medicine through quality programming and communication.

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

	Term Expires
Frank B. Norbury, Jacksonville, *Chairman*	1988
Donald Aaronson, Chicago	1987
Allison Burdick, Jr., Oak Park	1984
Eugene P. Johnson, Casey	1986
Eugene T. Leonard, Rockford	1985

Responsibilities and Purposes:

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*
Albert G. Bledig, Eldorado
Thomas Schrepfer, Havana

Responsibilities and Purposes:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

REPRESENTATIVES TO INA-ISMS JOINT PRACTICE COMMITTEE

Audley F. Connor, Jr., Chicago
Joseph Murphy, Chicago
Richard Suhs, Springfield
Risher Watts, Chicago

Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning and (6) identify and address the ensuing problems related to basic role reorganization.

ISMS REPRESENTATIVES TO OTHER GROUPS

Swanberg Foundation, Quincy
Robert R. Hartman, Jacksonville

Liaison to Ill. Soc. of the Amer. Assoc. of Med. Assts.
Robert R. Hartman, Jacksonville

Ill. Interagency Coun. on Smoking and Disease
Charles L. Swarts, Oak Park

Illinois Medical Records Assoc.
Clifton Reeder, Wilmette

MD Committee on Optometry
Joel Kaplan, Chicago

Statewide Cooperating Organizations Committee of the Commission on Children
Gayle Kates, Chicago

Illinois Cancer Council
Peter Friedell, Chicago

Citizens Committee for an Illinois Program to Control High Blood Pressure
David Berkson, Chicago

U.S. Pharmacopaeia
Joseph Skom, Chicago, *Delegate*
Vincent Costanzo, Chicago, *Alternate*

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in this issue. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____ CITY: _____ ZIP: _____
ADDRESS: _____
TELEPHONE: ( ) _____
COUNTY MEDICAL SOCIETY: _____
MEDICAL SPECIALTY AND TYPE OF PRACTICE: _____
COMMITTEE IN WHICH INTERESTED: _____
EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

ISMS SERVICES

Members of the Illinois State Medical Society benefit from a wide range of services, programs, and publications. These are developed in response to official actions and policies of the House of Delegates and implemented through the Board of Trustees. The headquarters staff has been structured to respond to the directives of the House and the Board and develops and coordinates activities to provide these services. Following is a brief description of the divisional structuring, organization and services of the Society and the headquarters office.

ADMINISTRATION

The Society has engaged Mr. Alexander R. Lerner as Executive Administrator. The Executive Administrator is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. In this position, the Executive Administrator:

- provides liaison with the Board of Trustees and implements their actions
- is responsible for direct support and staffing of the House of Delegates
- evaluates legal inquiries for appropriate referral to corporate counsel
- has final authority for management team program planning and implementation
- provides guidance to officers, trustees, committee chairmen and county society officers
- directs activity and organization of staff personnel
- serves as secretary-treasurer for the Illinois State Medical Insurance Services, Inc.

Society programs, issues and activities are coordinated administratively through delegation of managerial authority. The Deputy Administrator for Administrative Services, Associate Administrator for Communication, and the Assistant Administrators for Public Policy and Management Services administer this responsibility under the direction of the Executive Administrator.

The Deputy Administrator directs the activities of the Division of Medical Education, Administrative Records, and Meeting Services. Additionally, direct staff support is provided through the Deputy Administrator for the House of Delegates, Executive Committee, Policy Committee, Constitution and Bylaws Committee, the Educational & Scientific Foundation, Medical Students, Residents and the Benevolent Fund. The Deputy Administrator reports directly to the Executive Administrator.

The Associate Administrator for Communications is the Manager for the Divisions of Public Relations/Publications and Membership/Marketing Services. The Assistant Administrator for Public Policy is responsible for management of the Divisions of Governmental Affairs, Health Care Finance and Medical Services. The Assistant Administrator for Management Services is responsible for the Divisions of Finance and Accounting, Computer Services, Office Services and Personnel.

ADMINISTRATIVE SERVICES

Under direction of the Deputy Administrator for Administrative Services, management of activities pertaining to the Division of Medical Education, Administrative Records, and Meeting Services is accomplished. Included in the latter are membership benefits pertaining to the 50-Year-Club, Society-sponsored travel and insurance programs, and meeting services for the official bodies of ISMS. Additional responsibilities are assumed at the direction of the Executive Administrator.

Medical Education

The Society monitors changes in medical education, post graduate requirements for licensure and accreditation procedures. Educational matters are addressed through staff services to the Illinois Council on Continuing Medical Education, the ISMS Council on Education and Manpower and the Committee on CME Accreditation. In addition, staff services are provided to the Task Force on Health Professions, the Ad Hoc Committee on Financial Aid to Medical Students and the Committee on Loss Prevention Education. Various programs, seminars, symposia, and consultations, as well as publications, are developed for the membership in order to provide resources to physicians in the education milieu. Educational matters are addressed through the following services:

- ICCME—The Illinois Council on Continuing Medical Education is a unique organization jointly sponsored by ISMS and the State's eight medical schools, the purpose of which is to encourage the development of quality CME through formal learning programs, educational consultation and educationally related research.
- Council on Education and Manpower—This ISMS Council considers educational issues which affect the medical manpower and licensure needs of Illinois. Among this group's activities are periodic survey studies of Illinois physicians concerning their educational and practice needs, review of graduate medical requirements, and issues dealing with the funding of medical education.
- Committee on CME Accreditation—This Committee deliberates on the periodic accreditation status of Illinois CME sponsors and makes accreditation decisions.
- Committee on Loss Prevention Education—This Committee develops educational programs for Illinois physicians on malpractice/loss prevention and works to publicize the need for organized medicine to reduce exposure to medical malpractice litigation.
- Antidote—ISMS publishes this bimonthly claims flyer to assist Illinois physicians in recognizing the common causes of malpractice claims with high damage potential and tailoring their practice habits to avoid such risks.
- Liaison with appropriate state agencies and other groups—to assure that members are well informed concerning medical licensure requirements and procedures, as well as statewide issues affecting the development of quality medical education.

Meeting Services and Membership Programs

A number of programs and services are provided to Society members or sponsored for their benefit. These include the 50-Year-Club, meeting services and travel programs.

- The *50-Year-Club* consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives these members an opportunity to renew friendships.
- ISMS *meeting services* include provision for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
- Society-sponsored *travel programs* enable members to enjoy luxury cruises and tours. Qualified tour agencies are screened for professional, non-regimented trips.

Medical students and residents have formed affiliate sections within the Society. ISMS also conducts several programs for new physicians and those seeking either a medical education or an opportunity to practice in Illinois.

- The *Physician Recruitment Program* seeks to link communities in need of a physician with those seeking practice opportunities. Questionnaires on educational background, interests and practice preference are distributed to physicians who receive a complete list of openings in return. Communities seeking physicians contact the service for like information.
- The *Medical Student Loan Fund Program* is a joint effort of ISMS and the Illinois Agricultural Association. The Medical Student Loan Fund Board screens students whose college grades or MCAT scores are marginal and recommends special consideration by the UI College of Medicine in selected cases. In return, the student promises to practice in a rural community needing a physician for four or five years after graduation.
  The program also makes low interest loans available to students. Repayment is delayed until four years after graduation and the student makes a similar agreement to practice for a period in rural Illinois.
- A new loan program has been instituted through the ISMS Educational and Scientific Foundation, supported by a dues allocation and other grants. This program was initiated in 1983 through the Task Force on Financial Aid to Medical Students.
- The *MECO* (Medical Education Community Orientation) program seeks to encourage students to select careers in primary care.

In addition, this Division provides staff for the ISMS Insurance Committee which works through an independent broker as directed by the Board of Trustees, in sponsoring various insurance programs for the benefit of the membership. Each program has been scrutinized for quality and economy. A brief synopsis of each program follows:

Group Term Life Insurance

The group term life insurance program is underwritten by the North American Company for Life and Health Insurance. It offers:

* $25,000 to $1 million in level term life insurance
* a built-in waiver of premium
* availability to members, their spouses and employees under age 65
* coverage to $5,000 for members' children
* non-cancellable, guaranteed renewability to age 100
* conversion to permanent individual policy guaranteed to age 65

Group Disability Income Protection Program

The group disability income protection program is underwritten by the Commercial Insurance Company. It provides:

* $500-$3,000/month for total disability
* coverage renewable to age 70
* benefit period options of lifetime accident and sickness
* payable (1) to age 65; (2) for seven years; (3) five year accident and sickness payable for 2 years
* available to members and authorized employees or insured members to age 55
* benefits payable regardless of other insurance
* no restrictive riders attached after issuance
* individual coverage cannot be terminated

Professional Overhead Expense Plan

This plan is underwritten by the Hartford Accident and Indemnity Company and provides:

* $500-$5,000/month coverage
* office overhead expenses paid to maximum benefit selected beginning with 31st day of total disability
* benefits payable to 24 months regardless of other insurance
* new—accumulation benefit provided
* guaranteed issue for qualified new members under age 40 who apply within 60 days of effective date of membership
* available to all members under age 65 in full time practice
* rent, utilities, employee salaries and monthly *pro rata* of specified annual fixed expenses customary to the profession
* premiums deductible for individuals and partnerships under Revenue Ruling 55-264

The plan does not cover personal income, salaries for other physicians, principal payments on debts, implements, pharmaceutical products and personal insurance premiums.

Group Major Medical

The group major medical plan is underwritten by Commercial Insurance Company. It provides that the insured select a calendar year deductible of $500, $1,000 or $2,000 which applies to each insured person. It will then pay 80% of reasonable and customary expenses such as:

* semi-private room in the hospital
* hospital supplies and services, physician services, anesthetists, diagnostic lab and X-ray, registered nurses, ambulance services, prescription drugs and medicines, physiotherapy, therapeutic equipment rentals, artificial limbs, oxygen and blood.

The plan has a maximum out-of-pocket expense of $4,000 plus deductible and pays up to a lifetime maximum of $500,000 on health benefits. The plan is available to all members and qualified employees of insured members under age 55, and can be renewed up to age 65.

Medicare Supplement

The Medicare supplement plan is underwritten by the Hartford Accident & Indemnity Company. It covers charges for the following, incurred either as in-patient or out-patient:

* annual Medicare deductibles
* semi-private room and board
* diagnostic X-rays, lab tests, doctor's services, general nursing, drugs, anesthesia and many other hospital, medical and surgical services which are partially covered by Medicare.

The plan is available to members 65 and over and once

members are enrolled, their spouses may be insured on reaching age 65. Eligible applicants are guaranteed acceptance subject to a pre-existing condition limitation.

Excess Major Medical

This plan, underwritten by the Sentry Insurance Company, pays 100% of eligible medical expenses to ten years or $500,000. Selection of a $15,000, $20,000 or $25,000 deductible is available. The plan comes into effect when eligible medical expenses incurred within a three year period exceed the deductible. Evidence of insurability is not required. The plan will compensate up to 100% of the following:

* medical care
* physician medical care and treatment
* semi-private room and board
* private duty nursing services
* convalescent home confinement (up to $50/day and 90 days/year)
* physiotherapy by licensed physiotherapist
* prescription drugs, medicine and antibiotics
* dressings, casts, splints, trusses, braces and crutches; rental of wheelchair, hospital-type bed, iron lung and other therapeutic equipment; blood and blood plasma; X-ray and other radiotherapy; diagnostic tests and examinations; dental care for accidental injury of natural teeth; oxygen and anesthesia; ambulance service to $200 in any six month period; assistant surgeon to 20% of eligible expenses for chief surgeon; anesthesiologist to 15% of eligible expenses of chief surgeon.

The plan is available to members and their spouses, unmarried children under 25 and eligible full time employees under 65. Eligible applicants are guaranteed acceptance subject to a preexisting conditions limitation.

Hospital Indemnity Plan

The Hartford Accident and Indemnity Company underwrites the ISMS-sponsored hospital indemnity plan. Available plans provide benefits of $27.50, $55.00, $110.00 or $165 per day of hospital confinement. Benefits are also:

* initiated with first day of confinement
* payable to 365 days for each cause of confinement
* automatically doubled for hospital stays due to cancer or confinement in an ICU for persons under age 65
* payable regardless of other insurance

All members, their employees and families may participate. Acceptance of eligible applicants during special enrollment periods is guaranteed, subject to a pre-existing conditions limitation.

Workers' Compensation

Policies issued by the Casualty Reciprocal Exchange, a member of the Dodson Insurance group, are administered under the Dodson Savings Plan. Specific aspects include the following:

* return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders
* rates standard and approved for class of employment
* savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits

Accidental Death and Dismemberment

An accidental death and dismemberment plan is underwritten by the Hartford Accident & Indemnity Company. It provides coverage:

* for members, their spouses, children and employees
* a 24-hour business and pleasure coverage from $25,000 to $250,000
* renewable to age 70

Estate Planning

Corroon & Black of Illinois, Inc., offers estate planning services. These include:

* educational programs for county society meetings
* individual counseling

Administrative Records

The Division of Administrative Records is charged with responsibility for maintaining the listing of official actions and positions taken by ISMS' House of Delegates and Board of Trustees. The minutes and official transcriptions are maintained by this Division. In addition, records of all appointments and nominations are kept, as well as any other official documents. Staff services are provided the Committee on Committees.

COMMUNICATIONS

Under direction of the Associate Administrator for Communications, the activities of the Divisions of Public Relations/Publications and Membership/Marketing are coordinated. Both of these divisions work extensively with the membership of the Illinois State Medical Society to:

- provide information on a broad range of issues that affect physicians in their practice.
- provide a broad range of information to the media and public on the position of ISMS on important medical issues
- provide consultation and coordination to other ISMS divisions in the area of membership mailings, promotional design and layout, editing and creating copy, and distribution of membership information and public relations activities.

Membership/Marketing

The work of the Division of Membership/Marketing Services is concerned with retention and recruitment of ISMS members, and includes the following activities:

- Field Representation: Field representatives provide service to the members through their work with trustees, county society presidents, secretaries and staff, hospital medical staffs and physicians in clinics.
- President's Tour: The ISMS President visits with county medical society members and informs them of important society activities and takes their members' concerns to ISMS leadership.
- Physician File Maintenance: Communication with the members cannot be accomplished without a sophisticated physician data base. Physician and leadership addresses and membership status are updated daily.
- Recruitment: Recruitment of ISMS members is primarily the county medical society's job with assistance from this ISMS division.
- Member and Staff Information: Division staff members provide information and assistance to members, county society presidents and secretaries, ISMS staff, hospital medical staffs and others about ISMS membership and

about any issue of concern to the member. The Division is responsible for providing staff services to the Task Force on Membership/Marketing, the Ad Hoc Committee on Hospital Medical Staffs and the Council on Affiliate Societies.

In addition, the division staff provide administrative services to affiliated groups on a cost-allocated basis. These include office management, meeting arrangements, membership promotion and record maintenance, dues collection and accounting services.

Public Relations/Publications

Society staff members in the Division of Public Relations/Publications work to provide information to the ISMS membership through various publications, including:

- The *Illinois Medical Journal* which is published monthly to keep members aware of clinical, economic, legal, and political events;
- *Action Report* which is published periodically to inform members of Society activities and present news in the area of socio-economics;
- *On the Legislative Scene* is distributed on request to ISMS members during the General Assembly session to offer a status report on pending legislation of importance to Illinois physicians; and
- *AID (Athletics, Injury and Disease)* offers sports-medicine information to junior and senior high school coaches and trainers in Illinois to help them prevent, recognize and triage sports-related injuries and illnesses.

Society staff also produces publications for ISMS' affiliate groups, including:

- *Pulse of the ISMS Auxiliary* published quarterly for the ISMS Auxiliary features reports of membership activities and items of interest to physician spouses; and
- Affiliate group newsletters published for various state specialty societies, including the Illinois Psychiatric Society; Illinois Chapter, American Academy of Pediatrics; Illinois Society of Internal Medicine; Illinois Association of Ophthalmology; Illinois Radiological Society; Illinois Society of Anesthesiologists; Illinois Academy of Physician Assistants; and Illinois Society, American Association of Medical Assistants

As part of its public relations effort, division staff work to provide information concerning ISMS to the news media and public through such mechanisms as:

- Speeches prepared for ISMS officers, slide presentations and informational brochures;
- News releases publicizing ISMS actions and views;
- Public service announcements are produced and distributed to Illinois media to provide valuable health information to the general public.

Activities of the Division are directed by the Society's Publications Committee, IMJ Editorial Board, and the Council on Public Relations and Membership Services.

PUBLIC POLICY

The Assistant Administrator for Public Policy has overall responsibility for the Society's relations with governmental entities. The Assistant Administrator directs the Divisions of Governmental Affairs, including IMPAC, Health Care Finance and Medical Services.

Governmental Affairs

One of every five bills introduced in the General Assembly relates to health. The Society's legislation program is conducted under direction of the Governmental Affairs Council.

All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. When adequate review is completed and appropriate positions are developed, legislative representatives express the ISMS position to legislators, while also continually monitoring amendments to bills of interest to the medical profession. The Division also coordinates physician testimony before legislative committees to provide essential information to lawmakers.

Additional input and citizen involvement are developed through the Key Man Program and public affairs activity.

- The Key Man Program is a network of physicians or spouses who are relatives, friends or campaign supporters of Illinois legislators. Key men advise legislators on health legislation.
- Public Affairs activity includes sponsorship of speakers at Society meetings and liaison with government agencies. It encourages grassroots involvement in the political process. Also, the Division coordinates the activities of the Illinois State Medical Society Medical Political Action Committee.

Staff services are provided through both the Chicago headquarters and the Springfield Regional Office.

Health Care Finance

The Society provides services to members in the following aspects of Health Care Finance:

- Medicaid, Medicare & CHAMPUS—Services are provided in representation of member interests of a policy nature. Liaison is provided with Illinois Department of Public Aid and the Medicare fiscal intermediary to assure that member concerns are represented when policy changes are considered. Assistance is provided with payment delays, reimbursement errors and fiscal audits.
- Health Planning—Actions of Statewide Health Coordinating Council, Illinois Health Facilities Planning Board (CON), and local Health Systems Agencies are closely monitored and Society positions are expressed.
- Third Party Payors—The Division is directly involved in liaison activities with insurance carriers and government bodies on all economic issues relating to the practice of medicine, *e.g.*, hold harmless agreements and determinations of medical necessity. Through the Council and Committee structures, the Division performs research and monitors the developments of new reimbursement and health care delivery systems for the membership, *e.g.*, Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Utilization Review (Private and Peer Review Organizations [PROs]) and HMOs/IPAs.
- Health Data Systems—Government requirements for statistical information on health care and planning are monitored and Society positions are advanced.
- Drugs and Therapeutics—The Division provides staff assistance to the ISMS Committee on Drugs and Therapeutics. This committee meets regularly with the Illinois Department of Public Aid to review new drug products and make recommendations on those products for inclusion in the IDPA Drug Manual for Public Aid recipients.

The Division is available to assist members with questions or problems relating to health care programs and/or reimburse-

ment policies. The divisional staff is also available to assist members with questions or problems involving requests for drug product prior approvals from IDPA to ensure that physicians retain the ability to prescribe the appropriate drug product regimen for their patients to produce a successful medical result.

Medical Services

The Division of Medical Services is responsible for initiating, supporting, monitoring and implementing activities related to health care facilities, discipline of physicians, public and mental health, impairment, medical-legal issues, school and child health, maternal welfare, aging, sports medicine, and emergency medical services. These responsibilities are carried out through the following:

- Council and committee activities, where members and outside consultants examine, debate and formulate ideas and recommendations for consideration by the Board of Trustees;
- Development of educational materials and programs for the physician and his patient, to describe, inform, encourage or promote certain issues or subjects;
- Liaison activities with governmental, professional and consumer organizations, to promote and defend ISMS policies or concerns and educate others about issues important to physicians and monitor developments in order to inform the membership about changes impacting their practices.

The following Councils and their Committees are supported by staff of this Division: Panel for the Impaired Physician, Judicial Panel, Medical Legal Council, Council on Medical Services, Council on Mental Health & Addiction, Peer Review Appeals Committee. Ongoing liaison is conducted with various agencies to keep abreast of current developments and items of mutual concern.

FINANCE AND MANAGEMENT SERVICES

The Assistant Administrator for Management Services directs the Financial Management Activities, Computer Services, Office Services and Personnel Management.

Financial Management

Financial Management services are conducted under policies established by the Board of Trustees and Finance Committee. These activities include financial reporting, maintaining financial records for receipts and disbursements, budgeting, monitoring investments and securing assets.

Computer Services

As an integral part of financial management, electronic data processing capabilities are maintained to provide a cost-effective method to:

- Maintain membership and policyholder records.
- Provide central Society dues billings and collection for county medical societies.
- Provide invoicing for professional liability premiums.
- Maintain records and statistics on professional liability claims, policyholder files and other insurance related information.
- Process financial records.
- Provide word processing capabilities.

Office Services

Office Services provide building services for staff and physician meetings, mail and supply services, switchboard and receptionist and internal printing services for the Society and Insurance operations. Facility maintenance, telephone service and centralized purchasing are also under the Office Service function.

Personnel

Staffing for the Society is centralized under Personnel for recruiting, payroll, employee benefits, employee counseling and training and maintenance of personnel records

DIRECTORY OF MANAGEMENT STAFF PERSONNEL

The Illinois State Medical Society headquarters office is located at 55 East Monroe Street, Chicago, Illinois 60603. The telephone number is (312) 782-1654. In addition, a Springfield office is maintained at 702 South Second Street, Springfield, Illinois 62704, telephone (217) 528-5609.

Below are the key staff identified by managerial areas in keeping with the above itemization of responsibilities. Following the name of the individual is the telephone extension at the headquarters office.

EXECUTIVE OFFICE

Alexander R. Lerner, Executive Administrator 111

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Betty Kararo, Springfield Office Manager 217/528-5609

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Ancillary Organizations

Illinois State Medical Society Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to promote health awareness, medical legislation and funds for medical research and education (AMA-ERF).

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D.C. and had learned of the existence of the AMA Auxiliary and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, the ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927 with 25 members present. In 1928, the organization became permanent. Today, we have a membership of over 3400 and can look with pride on the auxiliary's accomplishments.

The auxiliary has instituted a large number of successful community health programs (*e.g.,* Vial of Life, Nutrition, Physical Fitness, Stress Management, Child Seat Belt Safety, Immunization). We have striven to educate the public on cost effective use of the medical care system and we have been highly successful in fund raising to provide financial assistance to medical students and medical schools (AMA-ERF).

Although we can look with pride upon what we have done, there is much that remains to be accomplished. For example, we will be increasing our fund-raising activities for medical education and research (AMA-ERF). Volunteer organizations such as ours will be assuming a primary role in dealing with society's health problems. We must work to convince other physician spouses that participating in Auxiliary activities is a worthwhile investment of time. Greater involvement with spouses of medical students and residents is encouraged through the SASH program (Sponsor A Spouse In Illinois). On the legislative scene, we provide information on health-related legislation, are a part of a legislative alert system and engage in face-to-face contact with legislators.

We recognize that it is our responsibility to provide leadership education for our up and coming county, state and national leaders. Thus, the inception of the State Leadership Seminars and participation in the AMA Auxiliary Confluence in October for county presidents-elect. We use our "PULSE" publication to communicate with the membership.

We are also concentrating our efforts on a closer working relationship with ISMS, as together, we meet the challenges of medicine in the '80's.

Officers

President ..... Mrs. Robert Webb, Edwardsville
President-Elect ..... Mrs. Robert Reardon, Bloomington
1st Vice-President
(Membership Coordinator) .. Mrs. Selig Hodes, Forreston
2nd Vice-President
(Program and Project Bank Coordinator) ..... Mrs. Wayne Kassel, Joliet
3rd Vice-President
(Health Projects Coordinator) ..... Mrs. Thomas Meirink, Belleville
Secretary ..... Mrs. L. P. Johnson, Rockford
Treasurer ..... Mrs. Julian Buser, Belleville

Directors

Mrs. Don Hinderliter, Rochelle
Mrs. Alan Taylor, Danville
Mrs. J. D. Winterhalter, Jacksonville

Parliamentarian

Mrs. Harlan Failor, Champaign

District Councilors

1. Mrs. Charles VanGorder, Geneva
2. Mrs. James Wilson, Princeton
3. Mrs. Gustavo Bermudez, Chicago
4. Mrs. John McLean, Peoria
5. Mrs. Wesley Betsill, Springfield
6. Mrs. Norman Taylor, East Alton
7. Mrs. Paul Stanley, Decatur
8. Mrs. Mack Hollowell, Charleston
9. Mrs. Gerald Fox, Mt. Vernon
10. Mrs. W. A. Simmons, Belleville
11. Mrs. August Martinucci, Jolict
12. Mrs. Raymond Hoffman, Rockford

Committee Chairmen

AMA-ERF ..... Mrs. J. D. Winterhalter, Jacksonville
Archives ..... Mrs. Louis Tisovec, Rockford
Benevolence ..... Mrs. Walter Stevenson, III, Quincy
Bylaws ..... Mrs. Harlan Failor, Champaign
Convention ..... Mrs. Norman Taylor, East Alton
Editor ..... Mrs. Philip Hays, Kankakee
Fall Conference ..... Mrs. John Leyland, East Peoria
Finance ..... Mrs. William Hodges, Kankakee
Health Projects
Coordinator ..... Mrs. Thomas Meirink, Belleville
Humanitarian ..... Mrs. Wayne Kassel, Joliet
Legislation ..... Mrs. Alan Taylor, Danville
Long Range Planning ..... Mrs. Robert Reardon, Bloomington
Membership Coordinator ..... Mrs. Selig Hodes, Forreston
Members-at-Large ..... Mrs. Alex Spadoni, Hinsdale
Program & Project Bank ..... Mrs. Wayne Kassel, Joliet
Public Relations ..... Mrs. G. Richard Locke, Decatur
RP/MSS Liaison ..... Mrs. Edward Kwedar, Springfield

Consultants

Child Seat Safety ..... Mrs. Ronald Severino, Wheaton
Cult Awareness ..... Mrs. George Olander, Lake Forest
Exceptional Person Awareness ..... Mrs. Gene Hoerr, Peoria

Representatives to ISMS Councils and Committees

Alcoholism and Drug
Dependenee ..... Mrs. Wayne Kassel, Joliet
Benevolence ..... Mrs. Louis Tarsinos, Princeton
Governmental Affairs ..... Mrs. Alan Taylor, Danville
Health Planning ..... Mrs. Thomas Meirink, Belleville
Mental Health & Addiction ..... Mrs. Alex Spadoni, Hinsdale
Public Relations & Membership
Services ..... Mrs. Robert Reardon, Bloomington
Medical Services ..... Mrs. Selig Hodes, Forreston
Sports Medicine ..... Mrs. Harold Keegan, Kankakee
Task Force on Financial Assistance to Medical
Students ..... Mrs. Don Hinderliter, Rochelle

Representatives to Outside Groups

Illinois Interagency Council
on Smoking and Disease ... Mrs. John Simonaitis, Elmhurst
INA-ISMS Joint Practice
Committee ..... Mrs. Larry Schick, Rockford

American Association of Medical Assistants, Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending medical assistant programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are: travel course, regional seminars, annual symposium, personal development day and the all day workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the house of delegates session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, 20 North Wacker Drive, Chicago IL 60606.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with over 500 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (*i.e.*, group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (Downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), West Cook (River Grove), Cook County South (Oak Forest), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), LaSalle, Macon (Decatur), McLean (Bloomington), Peoria, Randolph (Chester), Rock Island-Moline, St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will Grundy (Joliet) and Winnebago (Roekford). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact: Betty Kronemeyer, CMA, 809 N. 10th St., Mascoutah IL 62258 or Janet Binkowski, R.N., 428 Adams St., Dolton IL 60419.

Officers

President: Betty Kronemeyer, CMA, Mascoutah
President-Elect: Anna Cannon, Chicago
Immediate Past President: Janet Binkowski, RN, Dolton
1st Vice President: Shirley Fox, Sparta

2nd Vice President: Jean Fouts, LPN, Normal
Recording Secretary: Cheryl Smiley, CMA, Westville
Membership Secretary: Sandra Yenerich, RN, Homewood
Corresponding Secretary: Barbara Williams, CMA, Peoria
Treasurer: Dolores Dupree, Berwyn
Speaker of the House: Luella Mitchell, CMA, Chicago
Vice Speaker of the House: Pauline Klarich, Peoria
Board of Trustees, Chairman: Synobia Payne, Chicago
Parliamentary Advisor: Ruby Jackson, CMA, Chicago
Chaplain: Cheryl Hutchinson, CMA, Granite City
Historian: Linda Harp, CMA, Granite City

Physician Advisors

John L. Wright, M.D., Bloomington, *Chairman*
Thomas R. Harwood, M.D., Chicago
Peter C. Lee, M.D., Granite City
Leslie Schwartz, M.D., Chicago
Robert R. Hartman, M.D., Jacksonville, *Liaison to ISMS*
Robert E. Thompson, M.D., Peoria

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

Board of Directors

Cyril C. Wiggishoff, Chicago, *Chairman*
Jere Freidheim, Chicago
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Warren D. Tuttle, Harrisburg

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in cooperation with the state's eight medical schools, to fulfill these purposes: (a) encourage and assist in the development of continuing medical education programs for Illinois physicians that will enhance patient care; (b) study and encourage development of new educational methods, techniques, systems, *etc.;* (c) assist learning sources to identify the educational needs of Illinois physicians; and (d) stimulate, motivate, and encourage physicians at all levels throughout the state to participate in formal continuing educational programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee.

ICCME was officially chartered by the state as a nonprofit educational organization in May, 1972, and began operations in September, 1972. Financial support of the Council is provided primarily by ISMS members' dues.

ICCME unites the resources of the Illinois State Medical Society and the educational resources of the state's medical schools; it serves *all* interests concerned with CME and thus provides a crucial channel of communication to coordinate the efficient use of all available resources.

Current Major Activities

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois healthcare system in the Council's work. The eleventh annual congress will meet in 1983.
2. On behalf of ISMS, perform site visits for accreditation of intrastate CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME planning and organization.
4. Organize workshops on techniques of CME—including an unusual "Seminar on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. Included are *Your Personal Learning Plan,* a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME

planners. For all items now available, request "The Illinois Handbook on CME Planning—Catalog/Order Form." All publications are available to ISMS members at a 50% discount. To obtain a copy of the Catalog/Order Form just indicate this on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.

6. Prepare a monthly calendar of Illinois CME activities for *IMJ*.
7. Plan and conduct research studies that contribute to the improvement of CME methods.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: nine practicing physicians representing the State Medical Society and eight academic physicians/educators, one selected by each dean of an Illinois medical school.

Board of Directors

Harold A. Paul, M.D., M.P.H., *President*
Robert L. Prentice, M.D., *Vice-President*
Michael H.M. Dykes, M.D., M.Ed., *Secretary*
Lawrence L. Hirsch, M.D., *Treasurer*
Howard S. Barrows, M.D., Springfield
Robert A. Behmer, M.D., Rockford
Ben B. Blivaiss, Ph.D., North Chicago
Ernst Chester Bone, M.A., (Educ.), M.D., Jacksonville
Dean R. Bordeaux, M.D., M.A., (Educ.), Peoria
Linda K. Gunzburger, Ph.D., Maywood
Marten M. Kernis, Ph.D., Chicago
Alfred J. Kiessel, M.D., Decatur
Thomas P. Meirink, M.D., Belleville
Julius S. Newman, M.D., Aurora
Ward E. Perrin, D.O., F.A.C.O.I., Chicago
Donald F. Pochyly, M.D., M.Ed., Hines
Francis H. Straus, II, M.D., Chicago

Panel of Accreditation Site Visit Surveyors

Serving as Surveyors are Board Members of the Illinois Council on Continuing Medical Education and others chosen by the ICCME Board who meet criteria adopted by the ISMS Board of Trustees, March 31, 1979. ICCME does *not* make accreditation decisions, neither individual Board Members nor the Board collectively. Rather, the Survey Team's role is analogous to that of the physician who performs a physical examination on a potential purchaser of life insurance: to ascertain and report the facts, leaving to the underwriter the actuarial decision on granting insurance. The Survey Team makes a judgment on each of the seven "Illinois Criteria," on the basis of point values prescribed by the ISMS Committee on CME Accreditation, as well as the Team's conversation with the Sponsor. Individuals serving on the Panel of Surveyors, in addition to members of the ICCME Board, are (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D.
Anthony L. Barbato
Lloyd Barr, Ph.D.
Bradford W. Claxton, M.Ed.
Alfred J. Clementi
Joseph L. Daddino
John G. Demakis
Richard E. Dukes
Sherman Elias
L. Penfield Faber
Charles G. Farnum, Jr.
Peter O. Fried
Allan L. Goslin
Robert C. Hamilton
Robert R. Hartman
Henri S. Havdala
Thomas O. Henderson, Ph.D.
Eugene T. Hoban
John M. Holland
Kathryn S. Huss
Ross N. Hutchison
William L. Jackson
Frank J. Jirka, Jr.
Eugene P. Johnson
James M. Laidlaw
Howard B. Levy
Paul A. Maxwell, Jr.
Boyd E. McCracken, Sr.
Morgan M. Meyer
Joseph R. O'Donnell
Charles E. Osborne, Ed.D.
Joseph B. Perez
Mather Pfeiffenberger
Eugene Scherba
Joseph C. Sherrick
George Shropshear
Robert C. Stepto
Jacob R. Suker
L. W. Tanner
Sheldon S. Waldstein
Charles J. Weigel
Ruth Wharton
Fred Z. White, M.D., M.A.
George T. Wilkins
Roger A. Wujek

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC Board of Directors

Joseph Sherrick, Chicago, *President*
Robert P. Johnson, Springfield, *Vice-President*
James Laidlaw, Champaign, *Secretary-Treasurer*
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Lawrence L. Hirsch, Chicago
Robert Prentice, Springfield

Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee (IMPAC) is a voluntary non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his/her spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U.S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, 55 E. Monroe, Suite 3510, Chicago 60603.

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services, Inc. is an Illinois corporation, formed in March 1976, the capital stock of which is owned by the Illinois State Medical Society. It currently acts as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Inter-Insurance Exchange was organized as an insurance reciprocal to provide comprehensive professional liability insurance for Illinois physicians. Membership in the Exchange is limited to members of the Illinois State Medical Society. The Exchange is chartered under the laws of Illinois and functions under the Illinois Insurance Code.

Insurance Services provides management and underwriting services required for operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business. Within these policy guidelines Insurance Services provides management by accepting or rejecting applications, determining the form of insurance policies, and handling and disposing of claims. Insurance Services is compensated by the Exchange on the basis of expense reimbursement.

As a wholly-owned subsidiary, ISMIS provides certain services through ISMS on a shared basis. These shared services are on a direct cost reimbursement basis. Insurance Services itself includes four principal divisions: Underwriting, Claims, Medical Director and Administrative Services. In addition, shared services support is provided by ISMS through the Divisions of Marketing, Publications/Public Relations, Education, Governmental Affairs, Computer Services, Personnel, Finance and Accounting.

Offices of Illinois State Medical Insurance Services, Inc. are at 55 East Monroe, Suite 3440, Chicago, Illinois 60603 (312/782-2749).

Board of Directors

Clifton L. Reeder, M.D., *Chairman*
Phillip D. Boren, M.D.
Alfred J. Clementi, M.D.
Robert C. Hamilton, M.D.
J.M. Ingalls, M.D.
Warren D. Tuttle, M.D.

Officers

Clifton L. Reeder, M.D., *Chairman*
Paul E. Singer, *President*
Alexander R. Lerner, *Secretary-Treasurer*
Henry Nussbaum, *Vice President*

Resident Physicians Section

Brad Epstein, Chairman
David Whitney, Vice-Chairman
Mark Griffith, Secretary
Michael L. Nieder, Delegate
Charles Cattano, Alternate Delegate

Council Representatives

John Diveris, Education & Manpower
Peter Panton, Medical Services
Thomas Mizen, Medical-Legal
Joseph DiBeneditto, Public Relations
Frank Pieri, Mental Health & Addiction
Charles Cattano, Economics
Ronald Davis, Governmental Affairs

Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

Medical Student Section

Linda Tetzlaff Brubaker, Chairman
George Beranek, Vice Chairman
Dirk Proffer, Secretary
Patrick Merrill, Delegate
Karen Kawala, Alternate Delegate
Steven Kmucha, MECO Coordinator

School Representatives

Chicago Medical School
  Seth Reiner
Loyola University
  Tad Vail
Northwestern University
  Jeff Visotsky
Rush Medical College
  Leonard Fagan
Southern Illinois University-Springfield
  Alan J. Seharrer
Southern Illinois University-Carbondale
  Vacancy
University of Chicago
  Richard Terek
University of Illinois-Chicago
  Gail Williamson
University of Illinois-Champaign/Urbana
  Hal Bennett
University of Illinois-Peoria
  Vacancy
University of Illinois-Rockford
  Vacancy
Chicago College of Osteopathic Medicine
  Kevin Dolchide

Council Representatives

Paula Olen-Mikrut, Education & Manpower
Thomas Zusag, Economics
Steven Kmucha, Public Relations
Michael Brottman, Medical Services
Gail Williamson, Medical-Legal
Gail Herman, Mental Health & Addiction
Richard Terek, Governmental Affairs

Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

University of the Health Sciences/The Chicago Medical School
  3333 Green Bay Road, North Chicago, IL 60064
Northwestern University Medical School
  303 E. Chicago Ave., Chicago, 60611
University of Chicago-Pritzker School of Medicine
  950 E. 59th Street, Chicago, 60637
University of Illinois College of Medicine*
  Chicago Campus—
    1853 W. Polk Street, Chicago, 60612
Loyola University, Stritch School of Medicine
  2160 S. First Ave., Maywood, 60153
Rush Medical College
  1725 W. Harrison St., Chicago, 60612
Southern Illinois University School of Medicine
  801 N. Rutledge, P.O. Box 3926, Springfield, 62708

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).

ALLIED HEALTH EDUCATIONAL PROGRAMS

Accredited by the American Medical Association

Committee on Allied Health Education and Accreditation

CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center
University of Chicago—Lying-in-Hospital

ELECTROENCEPHALOGRAPHIC TECHNOLOGIST

SPRINGFIELD—St. John's Hospital

EMERGENCY MEDICAL TECH-PARAMEDIC

JOLIET—Silver Cross Hospital

HISTOLOGIC TECHNICIAN

CHICAGO—Holy Cross Hospital
St. Joseph Hospital
University of Chicago Lying-In Hospital
PEORIA—St. Francis Hospital and Medical Center
Methodist Medical Center of Illinois
SPRINGFIELD—Memorial Medical Center
St. John's Hospital

MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College
CARTHAGE—Robert Morris College
PALATINE—William Raincy Harper College
RIVER GROVE—Triton College

MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College
CHICAGO—Malcolm X College
DES PLAINES—Oakton Community College
DIXON—Sauk Valley College
EAST PEORIA—Illinois Central College
GODFREY—Lewis & Clark Community College
GRAYSLAKE—College of Lake County
KANKAKEE—Kankakee Community College
MORTON GROVE—Oakton Community College
PALOS HILLS—Moraine Valley Community College
QUINCY—Blessing Hospital
RIVER GROVE—Triton College

MEDICAL RECORD ADMINISTRATORS

CHICAGO—Chicago State University
University of Illinois at Chicago Hospital
NORMAL—Illinois State University

MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College
CHICAGO—Truman College
DES PLAINES—Oakton Community College
GLEN ELLYN—College of DuPage
GRAYSLAKE—College of Lake County
PALOS HILLS—Moraine Valley Community College

MEDICAL TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital
BELLEVILLE—St. Elizabeth Hospital
BLUE ISLAND—St. Francis Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Holy Cross Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Michael Reese Hospital & Medical Center
Rush-Presbyterian-St. Luke's Medical Center
St. Anne's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois at Chicago Hospital
DANVILLE—Lakeview Medical Center
DECATUR—Decatur Memorial Hospital
St. Mary's Hospital
EVANSTON—Evanston Hospital
FREEPORT—Freeport Memorial Hospital
HINES—Edward Hines Jr. V.A. Hospital
HINSDALE—Hinsdale Sanitarium & Hospital
JOLIET—St. Joseph Hospital
Silver Cross Hospital
MAYWOOD—Foster G. McGaw Hosp./Loyola University
NORTH CHICAGO—University of Health Sciences/Chicago Medical School
OAK LAWN—Christ Hospital
OAK PARK—West Suburban Hospital Association
PARK FOREST—Governors State University
PARK RIDGE—Lutheran General Hospital
PEORIA—Methodist Medical Center of Central Illinois
St. Francis Hospital and Medical Center
QUINCY—St. Mary's Hospital
ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital and Medical Center
Swedish American Hospital
SPRINGFIELD—St. John's Hospital
Sangamon State University
URBANA—Carle Foundation Hospital
WAUKEGAN—St. Therese Hospital

NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Illinois Masonic Medical Center
Northwestern Memorial Hospital
HINES—Edward Hines Jr. VA Hospital
OAK LAWN—Christ Hospital
PEORIA—St. Francis Hospital-Medical Center
RIVER GROVE—Triton College

OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois at Chicago Hospital

PERFUSIONIST

CHICAGO—Mt. Sinai Hospital Medical Center

PHYSICAL THERAPIST

CHICAGO—Northwestern University

RADIATION THERAPY TECHNOLOGIST

CHICAGO—Chicago State University
Michael Reese Hospital/City Wide College
ELGIN—St. Joseph Hospital
EVANSTON—National College of Education
HINES—Edward Hines Jr. VA Hospital
ROCKFORD—SwedishAmerican Hospital

RADIOGRAPHER

ARLINGTON HTS.—Northwest Community Hospital
BELLEVILLE—Belleville Area College
CARBONDALE—Southern Illinois University
CENTRALIA—Kaskaskia Junior College
CHAMPAIGN—Parkland College
CHICAGO—Cook County Hospital
DePaul University
Henrotin Hospital
Illinois Masonic Medical Center
Malcolm X College
Provident Hospital & Training School
Ravenswood Hospital Medical Center
St. Anne's Hospital
St. Joseph Hospital
South Chicago Community Hospital
University of Illinois at Chicago Hospital
Wilbur Wright College
DANVILLE—Lake View Medical Center
DECATUR—Decatur Memorial Hospital
DES PLAINES—Oakton Community College
DIXON—Sauk Valley College
EAST PEORIA—Illinois Central College
ELGIN—St. Joseph Hospital
EVANSTON—St. Francis Hospital
GALESBURG—Carl Sandburg College
GLEN ELLYN—College of DuPage
GRAYSLAKE—College of Lake County
HINSDALE—Hinsdale Sanitarium & Hospital
KANKAKEE—Kankakee Community College
KEWANEE—Kewanee Public Hospital
MACOMB—McDonough District Hospital
MALTA—Kishwaukee College
MOLINE—Black Hawk College/Lutheran Hospital
Moline Public Hospital
NORMAL—Brokaw Hospital
OLNEY—Richland Memorial Hospital
PALOS HILLS—Moraine Valley Community College
PEORIA—St. Francis Hospital Med. Center
QUINCY—Blessing Hospital
St. Mary's Hospital
RIVER GROVE—Triton College
ROCKFORD—Rockford Memorial Hospital
SwedishAmerican Hospital
ROCK ISLAND—Franciscan Medical Center
SOUTH HOLLAND—Thornton Community College
SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

RESPIRATORY THERAPIST

CHAMPAIGN—Parkland College
CHICAGO—Central YMCA Community College
Malcolm X College
Northwestern University
University of Chicago Lying-In Hospital
MOLINE—Black Hawk College/Lutheran Hospital
PALOS HILLS—Moraine Valley Community College
RIVER GROVE—Triton College
ROCKFORD—Rock Valley College
SPRINGFIELD—Lincoln Land Community College

RESPIRATORY THERAPY TECHNICIAN

BELLEVILLE—Belleville Area Jr. College
CHAMPAIGN—Parkland College
CHICAGO—Marion Adult Ed. Career Trng. Ctr., Inc.
Metropolitan Group of Hospitals
South Chicago Community Hospital
GLEN ELLYN—College of Dupage
KANKAKEE—Kankakee Community College
MOLINE—Black Hawk College/Lutheran Hospital
OAK LAWN—Christ Hospital
PALOS HILLS—Moraine Valley Community College
ROCKFORD—Rock Valley College
SPRINGFIELD—St. John's Hospital
WAUKEGAN—Victory Memorial Hospital

SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Mid-Amer RC Blood Srvs/C. Hymen Blood Center
University of Illinois at Chicago Hospital
PARK RIDGE—Lutheran General Hospital

SURGICAL TECHNOLOGIST

BELLEVILLE—Belleville Area College
CENTRALIA—Kaskaskia Junior College
CHAMPAIGN—Parkland College
EAST PEORIA—Illinois Central College
MOLINE—Moline Public Hospital
QUINCY—Blessing Hospital
RIVER GROVE—Triton College

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

Election of senators and representatives is determined in the apportioned districts throughout the state. One senator is elected from each of the 59 districts. Each Senate district contains two House districts. Members of the House of Representatives are elected from these 118 single member House districts.

The General Assembly convenes each year on the second Wednesday of January. The General Assembly is a continuous body during the two year term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. The committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

STATE OFFICERS
1983

Governor, James R. Thompson, Rep., Chicago
Lieutenant Governor, George H. Ryan, Rep., Kankakee
Secretary of State, Jim Edgar, Rep., Charleston
Comptroller, Roland W. Burris, Dem., Chicago
Treasurer, James H. Donnewald, Dem., Breese
Attorney General, Neil F. Hartigan, Dem., Chicago

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (60 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each house can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available at no cost to ISMS members. Also available are four-color maps which detail the boundaries of the Illinois legislative districts. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

DANGEROUS DRUGS COMMISSION

300 N. State Street, Chicago 60610, Phone: 312/822-9860
300 W. Monroe Street, Springfield 62706, phone: 217/782-0685
Thomas B. Kirkpatrick, Jr., Executive Director

The Dangerous Drugs Commission is the single state agency responsible for all drug abuse treatment and prevention in Illinois, and for the preparation of all drug abuse planning and allocation of state and federal drug abuse funds. Other responsibilities include scheduling of controlled substances, licensing of drug abuse programs and controlled substances research, and training.

Administrative Staff

Daniel W. Behnke, Deputy Director
Barbara Frazin-Weiner, Chief Counsel
Patricia J. Larsen, Special Assistant to the Director
Linda Hargnett, Chief, Office of Planning and Policy Development
Krishan Kaistha, Ph.D., Chief Toxicologist
Edward Duffy, Administrator, Management
Felix Matlock, Administrator, Field Operations
Neil A. Reilly, Administrator, Compliance and Enforcement
Louis DiFonso, Administrator, Program Services and Project Development

STATUTORY BODIES

Dangerous Drugs Commission

Michael A. Belletire, Springfield, *Acting Chairman*
Gregory L. Coler, Springfield
Donald Gill, Springfield
Robert Granzeier, Springfield
William Kempiners, Springfield
Michael Lane, Springfield
Jeffrey Miller, Chicago
Robin Morgenstern, Chicago
Joseph Skom, M.D., Chicago
James Zagel, Chicago

Dangerous Drugs Advisory Council

Judge L. Michael Getty, Dolton, *Chairman*
Mrs. Roalda J. Alderman, Chicago
David Bingaman, Oak Park
Peg Blaser, Springfield
David Blumenfeld, Esq., Chicago
Gary Clayton, Springfield
Richard M. Daley, Esq., Chicago
Sen. John D'Arco, Chicago
Rep. Loleta Didrickson, Homewood
Judge Gino diVito, Chicago
Sheriff Richard Doria, Wheaton
Ronald Dozier, Esq., Bloomington
Rep. John F. Dunn, Decatur
Samuel Enlow, R.Ph., Chicago
Sen. Forest Etheredge, Aurora
Marian Fiske, R.N., Chicago
Brenda Harrison, Springfield
Sen. George Hudson, Hinsdale
Robert P. Johnson, M.D., Springfield
Hal Ross Kessler, Chicago
Rep. Roger P. McAuliffe, Chicago
Sen. Dawn Clark Netsch, Chicago
Don Paull, Ph.D., Chicago
Harry Sholl, Lake Forest
Donna Simonson, Springfield
Rep. Terry Steczo, Country Club Hills
Robert B. Uretz, Ph.D., Chicago
Sen. Frank Watson, Greenville
Judge Daniel White, Chicago

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

160 North LaSalle Street, Room 1700, Chicago 60601
One North Old State Capitol Plaza, Springfield 62706
Gregory L. Coler, *Director*

The Illinois Department of Children and Family Services is the state agency responsible for providing child welfare services and child protection services to children and their families. The current caseload is more than 40,000 children and families. The Department's Division of Child Protection is responsible for investigating reports of suspected child abuse and neglect; in fiscal year 1983, some 63,263 children were reported as suspected abuse or neglect victims. A new Division of Youth and Community Services coordinates the provision of a number of special services for adolescents.

Services provided by the Department, either directly or through purchase from private agencies, include counseling/advocacy, homemakers, day care and child development, foster family home and other residential care, and parent education.

Director's Office

Iris Slack, Deputy Director for Policy and Plans
Gordon Johnson, Deputy Director for Program Operations
Thomas Walsh, Deputy Director for Management and Budget
William Ryan, Acting Deputy Director for Child Protection
Peter Digre, Deputy Director for Youth and Community Services

Donald H. Schlosser, Chief of Communication/Community Relations
Mark Paulsen, Acting Chief Legal Counsel
Bruce Rubenstein, Legislative Liaison
Mauriece Graham, Chief of Internal Audits
Paul Freedlund, Special Assistant to the Director

Regional Offices

Thomas Brinton, Region 1A Administrator, Rockford
Thomas Ward, Region 1B Administrator, Peoria
John Robinson, Region 2A Administrator, Peoria
Roland Kulla, Region 2B Administrator, Aurora
William Gillespie, Region 3A Administrator, Springfield
Willis Hartman, Region 3B Administrator, Champaign
Anthony Jenkins, Region 4 Administrator, East St. Louis
Gene Ruehmkorff, Region 5 Administrator, Marion

Advisory Councils

DCFS Advisory Council, Nancy Peterson, Chairperson
Statewide Citizen's Committee on Child Abuse and Neglect, Penny Kendall, Chairperson
Statewide Day Care Advisory Committee, Lana Hostetler Chairperson
Illinois Juvenile Justice Commission, Larry L. Thompson, Chairperson

In addition to the above, each of the eight regions has its own advisory committee.

DEPARTMENT OF CORRECTIONS

160 N. LaSalle
Chicago, IL 60601
(312) 793-2955
1301 Concordia Court
Springfield, IL 62702
(217) 522-2666
Michael P. Lane, *Director*

Leo L. Meyer, Deputy Director-Adult Institutions
James R. Irving, Deputy Director-Juvenile Division
Douglas A. Brown, Deputy Director-Community Services
J. Thomas Hutchison, Deputy Director-Bureau of Administrative Services
Dr. William H. Craine, Deputy Director-Bureau of Employee and Inmate Services
Robert H. Klemm, Deputy Director-Bureau of Inspections and Audits
John Dreiske, Deputy Director-Bureau of Policy Development
Samuel J. Sublett, Accreditation Manager
Nic Howell, Public Information Officer
Dr. Richard Shansky, Medical Director

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the custody and rehabilitation needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, rehabilitation and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the State.

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601
Michael A. Belletire, *Acting Director*
Roalda J. Alderman, *Associate Director for Alcoholism*
Paul Schyve, M.D., *Acting Associate Director for Mental Illness*
William K. Murphy, *Associate Director for Developmental Disabilities*
John P. Harcourt, Jr., *Associate Director for Support Services*

Office of the Director

Russell Blaauw, Legislative Liaison
Douglas Carey, Director of Communications
Maureen D. Mudron, General Counsel
Michael P. Frampson, Special Assistant
David B. Thomas, Chief Auditor
Dorothy Ackman, Administrative Assistant
Harriett Mitchell, Administrative Assistant

Director's Executive Council Members and Regional Administrators

Roalda J. Alderman, Associate Director for Alcoholism
Paul Schyve, M.D., Acting Associate Director for Mental Illness

William K. Murphy, Associate Director for Developmental Disabilities
John P. Harcourt, Jr., Associate Director for Support Services
Douglas Carey, Director of Communications
Maureen D. Mudron, General Counsel
Ivan Pavkovic, M.D., Administrator, Illinois Mental Health Institutes
Donald W. Hart, Region 1 Administrator, Rockford
Patricia Barger, Ph.D., Region 2 Administrator, Chicago
Ugo Formigoni, Region 3 Administrator, Springfield
Ronald G. Bittle, Ph.D., Region 4 Administrator, Anna

STATUTORY BOARDS AND COUNCILS

1. Commission on Mental Health and Developmental Disabilities

Sen. Jack Schaffer, Crystal Lake, *Chairman*
Rep. Helen Satterthwaite, Champaign, *Vice-Chairman*
Rose Poelvoorde, Silvis, *Secretary*
Judy Buchanan, Bloomington
Hon. John Carroll, Park Ridge
Dr. James Cavanaugh, Chicago
Sen. Earlean Collins, Chicago
Sen. Vince Demuzio, Carlinville
Sen. Beverly Fawell, Glen Ellyn
Sen. Roger Keats, Kenilworth
Robert Lambourn, McHenry
Henry Murray, Quincy
Sen. Richard Newhouse, Chicago
Rep. James Reilly, Jacksonville
Rep. Alfred Ronan, Chicago
Hon. Esther Saperstein, Chicago
Rep. Terry Steczo, Country Club Hills
Rep. Sam Vinson, Clinton
Margaret M. Hastings, Ph.D., Chicago, *Executive Director*

2. Psychiatric Advisory Council

Michael A. Belletire, Springfield, *Chairman*
Wayne R. Anable, M.D., Chicago
Robert A. deVito, M.D., Chicago
Jan Fawcett, M.D., Chicago
Daniel X. Freedman, M.D., Chicago
Leroy P. Levitt, M.D., Chicago
A. S. Norris, M.D., Springfield
Daniel Offer, M.D., Chicago
Ivan Pavkovic, M.D., Chicago
George H. Pollock, M.D., Chicago
Lester H. Rudy, M.D., Chicago
Paul Schyve, M.D., Chicago
John C. Steffek, M.D., Chicago
Michael Taylor, M.D., North Chicago
Harold M. Visotsky, M.D., Chicago

3. Citizens' Advisory Council on Alcoholism

Richard G. Banta, M.D., Rockford
John C. Clarno, DDS, Park Ridge
Richard Dechert, Decatur
Antonio Garcia, Chicago
LaVerne M. Hawes, Chicago
Geraldine H. Jenkins, Ph.D., E. St. Louis
Robert S. Kincheloe, Chicago
David V. Koch, Anna
James H. Oughton, Jr., Dwight
John Smith, Chicago
W. David Steed, M.D., Oak Park
Peter Talso, M.D., Evergreen Park
Barbara Volkmann, Kankakee
Michael A. Belletire, Springfield
Gregory L. Coler, Springfield
Robert Granzeier, Springfield
William Kempiners, Springfield
Jeffery C. Miller, Springfield
Michael Lane, Springfield
Thomas Kirkpatrick, Springfield

4. Citizens' Advisory Council for Community Services

Philip Carlson, Peoria, *Chairman*
James Agner, Jacksonville
William N. Frayser, Broadview
Helen Hudlin, Ph.D., E. St. Louis
Thomas K. Janssen, Nashville
Sr. Chaminade Kelley, Springfield
Arnold Levin, Ph.D., Chicago
Frank Lynch, Lockport
Paul B. Musgrove, Peoria
Robert Norris, Evergreen Park
Patricia G. Olson, Rockford
Samuel A. Patch, Chicago
Guy A. Renzaglia, Ph.D., Murphysboro
John Smith, Chicago
Shirley Raskin Starr, Evanston

DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield, 62701
Jeffrey C. Miller, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

Administrative Staff

Carl Mankowitz, Deputy Director
Tim Claborn, Legislative Liaison
Johnetta W. Jordan, Chief, Office of Public Information
H. Dickson Buckley, Special Assistant to the Director
Louis Bosco, Chief, Office of Personnel Management and Labor Relations
Verne H. Evans, Chief, Office of Hearings/Recoveries

David Rakov, General Counsel, Office of Counseling/Litigation
Daniel McCarthy, Chief Auditor
Mary Ann Langston, Policy & Planning Administrator
Norman Ryan, General Services Administrator
Gail Huecker, Operations Administrator
Betsy Skloot, Medical Programs Administrator

Legislative Advisory Committee on Public Aid

Sen. Richard H. Newhouse, Chicago, *Chairman*
Sen. John Grotberg, St. Charles, *Vice Chairman*
Rep. Ethel Skyles Alexander, Chicago
Rep. Barbara Flynn Currie, Chicago
Sen. Glenn Dawson, Chicago
Rep. Susan L. Deuchler, Aurora
Rep. Joseph Ebbesen, DeKalb
Rep. Virginia Frederick, Lake Forest
Sen. Kenneth Hall, E. St. Louis
Rep. Douglas Huff, Jr., Chicago
Sen. Robert Kustra, Glenview
Rep. Virginia MacDonald, Arlington Heights
Rep. Josephine Oblinger, Springfield
Rep. Taylor Pouncey, Chicago
Sen. George Sangmeister, Joliet
Sen. Jack Schaffer, Cary

State Medical Advisory Committee

Fred Z. White, M.D., Chillicothe, *Chairman*
Michael J. Carbon, M.D., Chicago
Audley F. Connor, Jr., M.D., Chicago
Robert DeCook, M.D., Downers Grove
Randolph Emerson, M.D., Decatur
Chas. R. Frazer, M.D., E. St. Louis
Donald Hoard, M.D., Chicago
Terry Mason, M.D., Chicago
Boyd McCracken, M.D., Greenville
George T. Mitchell, M.D., Marshall
Robert C. Muehrcke, M.D., River Forest
Paul M. Norris, M.D., Peoria
Ann Pearson, M.D., Springfield
Dennis A. Reter, M.D., Canton
Arthur Traugott, M.D., Urbana

DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706
William L. Kempiners, *Director*

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Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
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Division of Disease Control

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The department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee, appointed by the director of the Department, operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, reviews alleged violations of the Medical Practice Act, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

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MEDICAL PRACTICE ACT

The annual reference issue ordinarily includes sections on the Medical Practice Act and medical-legal issues. This year, those topics will be covered through another vehicle.

In a few months, the Journal *will initiate a series of features on medical-legal issues. The first will be an analysis of legal provisions for medical discipline in Illinois. That analysis will include pertinent sections of the Medical Practice Act, and commenton the rules and regulations which pertain to physicians.*

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DORS assists clients in selecting the needed services; serves as a link to service groups, rehabilitation facilities and other governmental agencies; and makes medical eligibility determinations for persons applying for benefits under the Social Security Disability Insurance and Supplemental Security Income programs.

DORS offers its services through a number of program components, including the vocational rehabilitation program, the home services program, the Illinois Visually Handicapped Institute, Community/Field Services for the Visually Impaired, the Illinois School for the Deaf, the Illinois Children's School and Rehabilitation Center, the Illinois School for the Visually Impaired, the Secondary Work Experience Program and the Vending Stand Division.

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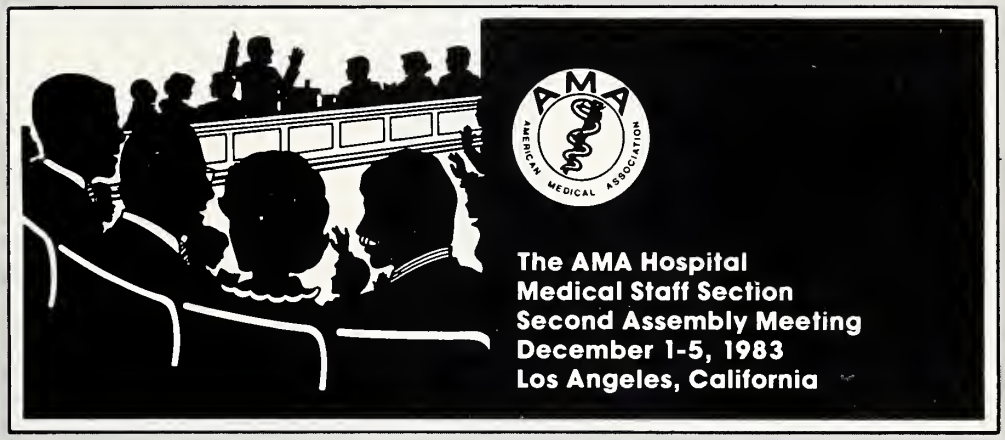
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Group sessions will be conducted on various topics of interest to hospital medical staff members. Scheduled presentations will include: diagnostic related groups (DRGs), credentialing, hospital contractual relations, prospective reimbursements, and overall relationships between physicians and hospitals.

Here's your opportunity to effect change. For information contact the AMA Department of Hospital Medical Staff Services at (312) 751-6656.

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Illinois State Medical Society
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55 East Monroe Street
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To Our 1983 PAC contributors:

On behalf of the Illinois State Medical Society Political Action Committee and the ISMS Board of Trustees, please accept my gratitude for your voluntary contributions to the PAC in 1983. Your voluntary contributions, either included with your dues payment, or sent to us in response to our solicitations, will go toward support of incumbents and challengers who give medicine a fair hearing on legislative issues.

It is not too early to begin thinking about the November 1984 elections. You have already taken your first political step by contributing to the PAC this year. Your next step should be to offer your support to a good candidate for the state legislature and Congress in your district. ISMS will be happy to identify your legislative and congressional districts if you complete and return the form below.

In October, ISMS will begin its renewal cycle for 1984 membership. We appreciate your past support. We urge you to continue your support for the 1984 elections.

Sincerely,

C.C. Wiggishoff M.D.

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Tranxene studies have not specifically investigated amnesia or rebound insomnia—but the record is impressive. In over a decade of widespread Tranxene experience there have been no reports in the medical literature linking Tranxene to any of these problems.

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TRUST TRANXENE®

(clorazepate dipotassium ℞)

3.75, 7.5, and 15 mg capsules

Please see brief summary on an adjacent page.

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant.

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

TRUST TRANXENE®
(clorazepate dipotassium Ⓒ)
3.75, 7.5, and 15 mg capsules

Abbott Pharmaceuticals, Inc.
North Chicago, IL 60064

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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

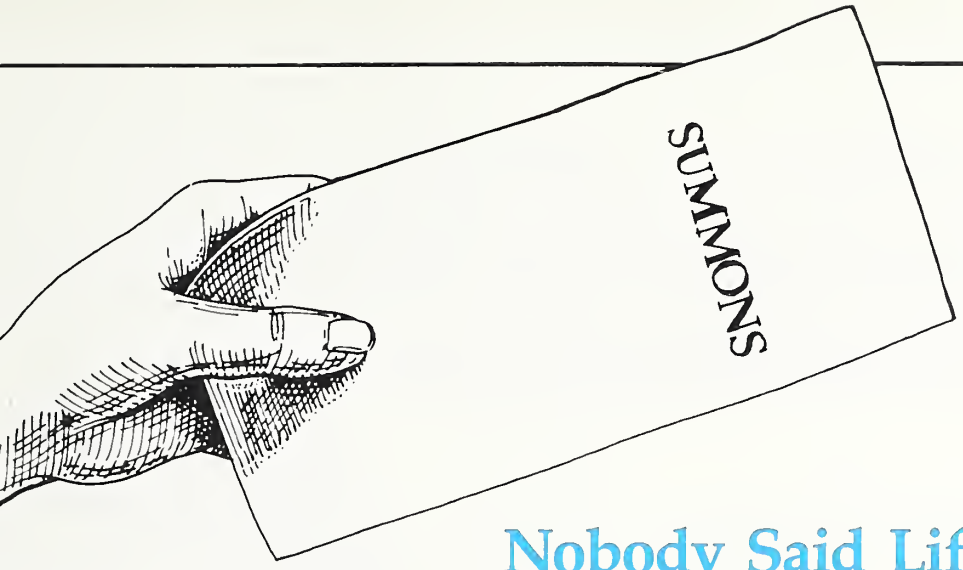
The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

November 1	Illinois Interagency Council on Smoking & Disease	Chicago
November 1	Carle Clinic Assn & ACS	Urbana
November 1	Northwestern Memorial Hospital	Chicago
November 1	St. Elizabeth's Hospital & ACS	Belleville
November 7	Lutheran General Hosp. & Chicago Lung Assn.	Park Ridge
November 7	Hinsdale Sanitarium & Hospital & ACS	Hinsdale
November 7	Evanston Freedom from Smoking Clinic	Evanston
November 14	Silver Cross Hospital & ACS	Joliet
November 15	Olympia Fields Osteopathic Med Cntr & ACS	Olympia Fields
November 15	Oak Park Freedom from Smoking Clinic	Oak Park
December 5	ANCHOR	Chicago
December 6	Illinois Interagency Council on Smoking & Disease	Chicago
January 3	Illinois Interagency Council on Smoking & Disease	Chicago
January 10	Northwestern Memorial Hospital	Chicago
January 17	Carle Clinic Assn & ACS	Urbana
February 1	Illinois Interagency Council on Smoking & Disease	Chicago
March 6	Northwestern Memorial Hospital	Chicago
March 6	Illinois Interagency Council on Smoking & Disease	Chicago
April 3	Illinois Interagency Council on Smoking & Disease	Chicago
May 1	Northwestern Memorial Hospital	Chicago
May 1	Illinois Interagency Council on Smoking & Disease	Chicago
June 5	Illinois Interagency Council on Smoking & Disease	Chicago



Nobody Said Life Was Fair!

Life hasn't been fair to physicians lately. Skyrocketing malpractice claims and whopping damage awards have caused premiums for malpractice insurance to soar.

Like other insurers, the Illinois State Medical Inter-Insurance Exchange has not been immune to rising professional liability costs, and premiums have had to be increased accordingly. At the same time, the Exchange — through its physician ownership — is constantly striving to maintain reasonable and equitable insurance premiums by making appropriate changes in its underwriting program.

That's why the Exchange has undertaken the most comprehensive restructuring of its professional liability program since 1977. Many revisions have been made for the 1983-84 program year — including creation of a lower risk classification and a third rating territory which will provide some physicians with premium reductions.

Illinois counties that have favorable loss experience have been assigned lower rates. Based on loss experience data pertaining to specialty and procedures performed, the Exchange was able to further refine its underwriting program to more accurately reflect practice exposures.

The Exchange is dedicated to maintaining a viable, responsive and fiscally sound insurance program for the long-term benefit of its members. We will continue to make revisions in our professional liability program as evidence of our commitment to provide Illinois physicians with the best professional liability protection available in the most equitable manner possible.

Physician Ownership Makes a Difference!

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55 East Monroe Street ● Chicago, Illinois 60603 ● 312/782-2749

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PRDCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PRDCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PRDCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PRDCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nitedipine. PRDCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

rocardia is indicated for the management of:
) Confirmed vasospastic angina.
) Angina where the clinical presentation suggests a possible asospastic component.
) Chronic stable angina without evidence of vasospasm in atients who remain symptomatic despite adequate doses of eta blockers and/or nitrates or who cannot tolerate these gents. In chronic stable angina (effort-associated angina) ROCARDIA has been effective in controlled trials of up to ight weeks' duration in reducing angina frequency and ncreasing exercise tolerance, but confirmation of sustained ffectiveness and evaluation of long-term safety in these atients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

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A complete diagnostic facility with state-of-the-art equipment

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Doctor's News

PHYSICIANS IN THE NEWS—**Wilton H. Bunch, M.D.,** Oak Park, has been elected to the American Orthopaedic Association (AOA) board of directors.

Lucius C. Earles III, M.D., Chicago, has been elected president of the National Medical Association (NMA) for a one year term.

Dharmapuri Vidyasagar, M.D., Oak Brook, has been chosen president-elect of the Society of Critical Care Medicine.

C. Thomas Bombeck, M.D., Oak Park, was recently elected to fellowship in the American Surgical Association.

REHABILITATION MEDICINE ANNUAL MEETING—The combined annual meetings of the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation will be held November 6-11 at the Westin Bonaventure Hotel in Los Angeles. For more information call Marvin Schroder, director of information, (312)236-9512.

INTERNATIONAL SYMPOSIUM—The Italian Society of Neurosurgery will sponsor a symposium on the biochemistry of acute spinal cord injury paraplegia, November 14 in Venice, Italy. Further information may be obtained by writing Vincenzo Lombardi, M.D., Piazza Garibaldi 48, 70021 Acquaviva, Italy. (Tel. (080) 762935.)

INTERNAL MEDICINE CONFERENCE—General practitioners, internists, family physicians and specialists in geriatrics are invited to attend a three day conference on cardiac, gastroenteral and renal disease, November 30 through December 2, at the Drake Hotel, Chicago. The program, sponsored by the University of Illinois College of Medicine, is part of the annual series titled, "Internal Medicine for the 1980s." For registration information contact the Office of Conferences and Institutes, University of Illinois at Chicago, PO Box 6998, Chicago, IL 60680 or phone (312) 996-8025.

HEALTH CARE TELETRAINING—A seminar on providing training and continuing education programs via cost-effective two-way telecommunications will be held on December 7-8 at the University of Wisconsin. "Teletraining in Health Care/Education" will be conducted via audio teleconferencing allowing participants to experience teletraining first hand. For more information contact the Center for Interactive Programs, 975 Observatory Dr., Madison, Wisconsin 53706, or phone (608) 262-2831.

CARDIOVASCULAR SYMPOSIUM—"Cardiovascular Disease: Major Advances in Diagnosis and Therapy" will be the theme of the 16th annual symposium sponsored by the American College of Cardiology (ACC) and the Hahnemann University School of Medicine, December 9-11, in New York City. For more information contact the ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814.

SPORTS MEDICINE CONFERENCE—The White House Symposium on Physicial Fitness and Sports Medicine will be held November 16-17 at the Mayflower Hotel, Washington, DC. For more information call Jan Schweiker (202) 667-5739.

AMA HOUSE OF DELEGATES—The American Medical Association Interim Meeting House of Delegates will be held December 4-7 at the Biltmore Hotel, Los Angeles. For more information contact Thomas G. Tofty, (312) 751-6594.

SUPPORT EDUCATION—The Illinois State Board of Education is seeking support in the celebration of 100 years of progress in Illinois education since the first school attendance laws were enacted in 1883. Illinois schools are conducting activities to celebrate their heritage and the future of education with the theme, "Education is Everyone's Future." Individuals can participate in this celebration by offering services as cosponsors and resource persons for school activities. Further information may be obtained through the Illinois State Board of Education, 100 N. First St., Springfield 62777.

PSYCHOLOGICAL FACTORS IN TREATMENT OF CANCER—The Preventive Medicine and Health Institute and Harding Hospital are co-sponsoring a seminar titled, "Cancer, Body/Mind Connection" November 11 at the Ohio Dominican College. The program, on the psychological factors in etiology, treatment and prognosis of cancer, has been approved for four hours Category 1 CME credit. The fee is $35 ($20 for students). For registration and program information contact the Preventive Medicine and Health Institute, 1460 W. Lane Ave., Columbus, Ohio 43221 or call (614) 488-5971. ◀



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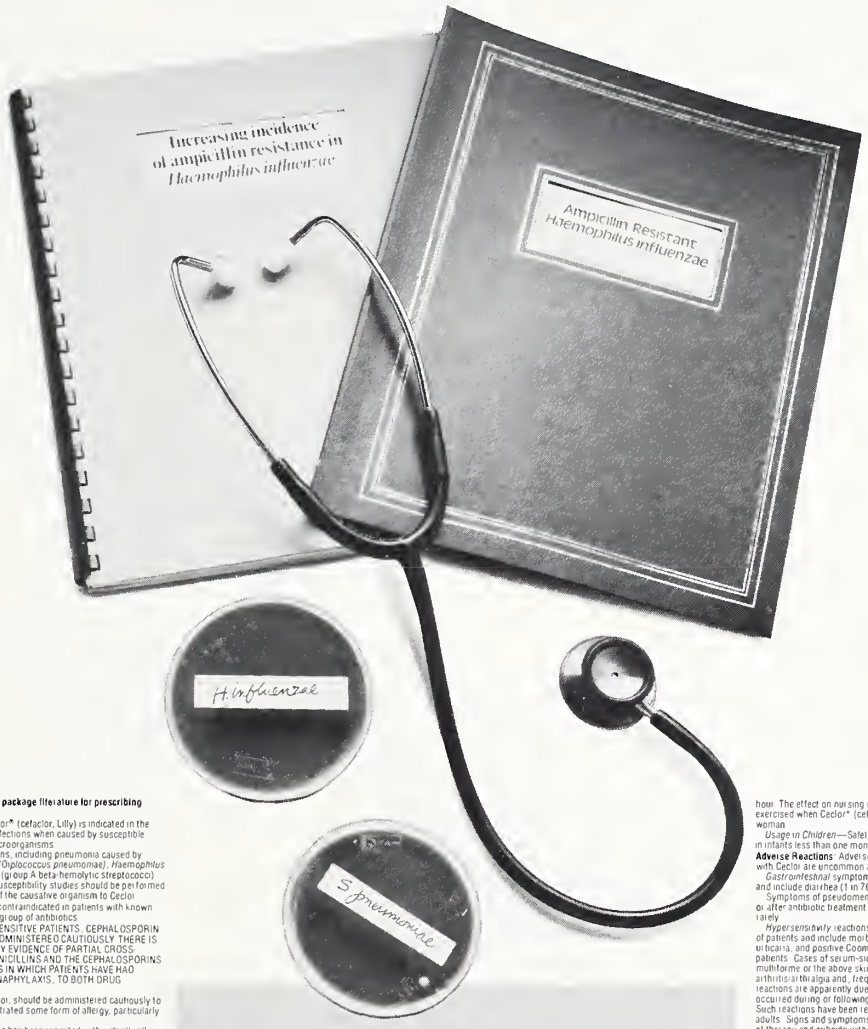
Meetings* are scheduled weekly in Steamboat Springs, from December 10th through April 14th and are approved for AMA, Category 1.

For information call: 800-525-3402

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary **Consult the package literature for prescribing information.**

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*: 91, 1975.
2. Antimicrob. Agents Chemother., *11*: 470, 1977.
3. Antimicrob. Agents Chemother., *13*: 584, 1978.
4. Antimicrob. Agents Chemother., *12*: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), p. 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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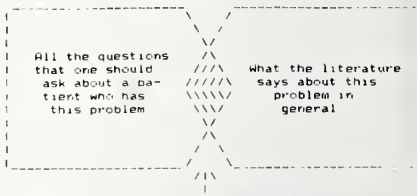
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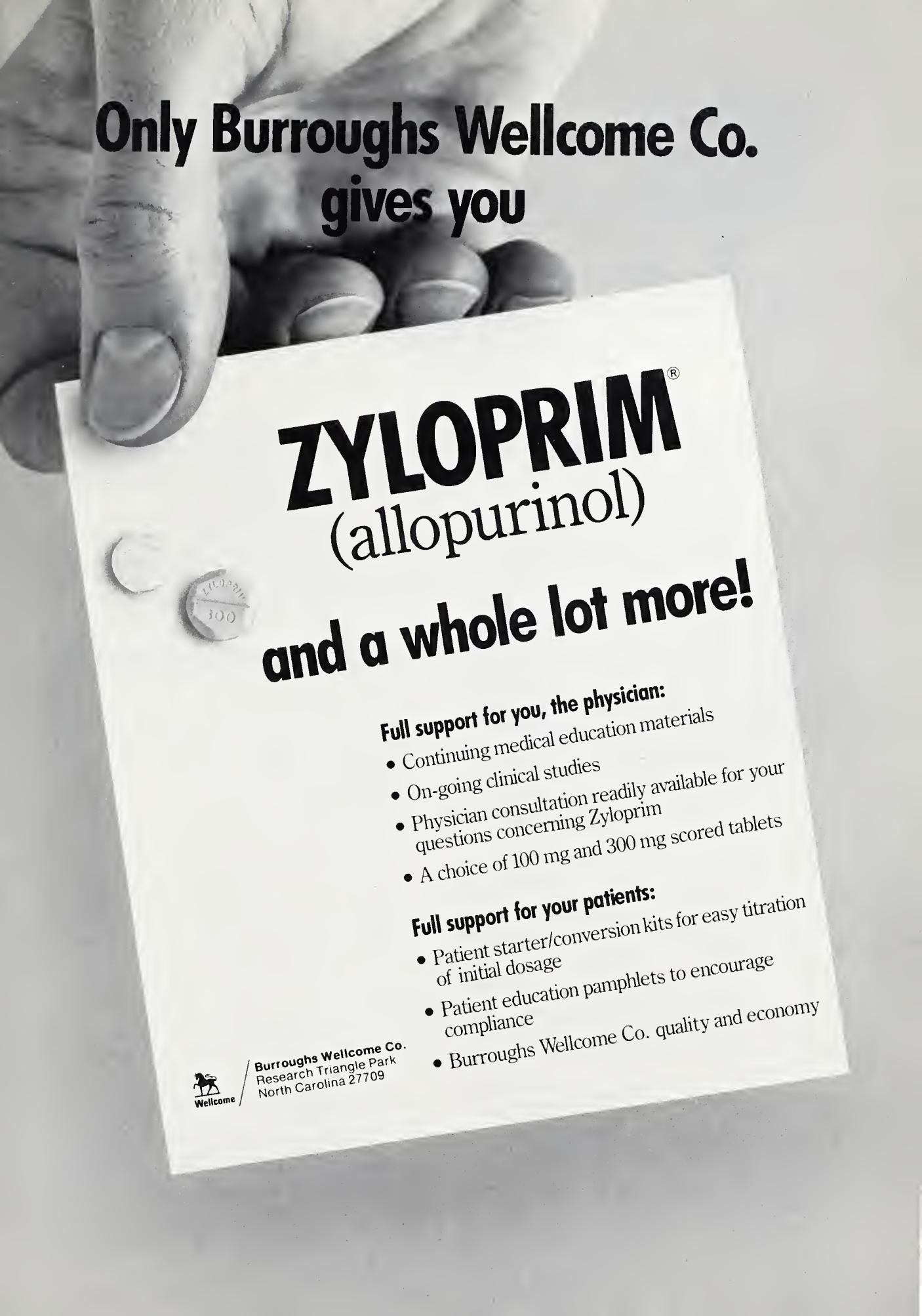
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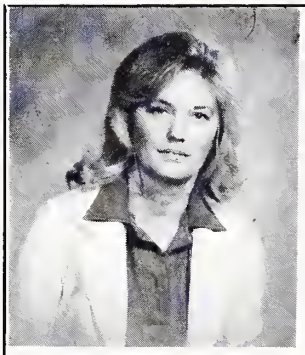


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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC, National Academy of Sciences, 1980, p. 13.

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Nominations Sought For ISMS Team Physician Award

The Illinois State Medical Society is accepting nominations for the 1984 ISMS Team Physician Award, which is presented annually to outstanding physicians who contribute their skills to young athletes in Illinois. The award also is designed to encourage other physicians to devote some of their time to serving as team physicians.

Award presentations will include recognition of the recipients at a major Illinois athletic event. (The 1983 award recipients were announced during the state's high school basketball tournament.) Physicians also will be recognized before their professional peers at the ISMS annual meeting.

Recipients of the 1983 ISMS Team Physician Award were Drs.: Edward Grogg, of Mahomet; Robert Hart and William Hart, of Peoria (who shared an award); Kenneth Malmberg, of Auburn; William Schiffbauer, of Streator, and George Wilkins Jr., of Granite City.

"I was very honored to receive the award," Dr. Grogg said. "I think (serving as a team physician) is an extremely rewarding experience. It's a constant source of enjoyment to be dealing with the cream of American youth."

Dr. Grogg has served as team physician for about 12 years.

The other recipients shared his enthusiasm for the job and encouraged other physicians to consider working as a team physician.

"Coaches feel much more secure when they know a team physician is around," said Dr. Malmberg, who has served as team physician for more than 40 years. "There's a real need for more team physicians; after all, we want our young people to be treated correctly."

"I don't know any disadvantages to the job," said Dr. Wilkins. "And there are many advantages. Mainly, your're out helping the kids." Dr. Wilkins has served as team physician for more than 20 years.

Both Dr. Robert and William Hart said that becoming a team physician was a "natural extension" of their interest in athletics.

"I use to play football," said Dr. Robert Hart. "I felt this (being a team physician) was one way to fulfill my obligations and interests to the school."

"I was always interested in team activities," said Dr. William Hart. "This just seemed like the natural thing to do—to gravitate to the medical end of it."

The Hart brothers have served 35 and 32 years respectively.

"Being a team physician takes time. And you must understand the athlete at the age he is," said Dr. Schiffbauer, who has served for more than 25 years. "By and large, you've got to be enthusiastic about young people."

"It's a very rewarding experience," he added.

Up to five physicians are honored annually with a distinctive plaque commemorating their service to athletic teams. Articles about selected team physicians appear in local newspapers and the *Illinois Medical Journal.*

Eligibility

Team physicians nominated must meet the following eligibility criteria:

(A) Maintain a license to practice medicine in all of its branches.

(B) Hold tenure as a team physician at the high

school or college level for a minimum of 10 years in a voluntary or paid capacity. (The physician need not have worked with the same team, or for consecutive years); and

(C) Maintain a current membership in the Illinois State Medical Society. Retired physicians are eligible for the award.

How To Nominate

Anyone may nominate a team physician for the award. Coaches, schools, athletes, parents, civic organizations and other physicians are urged to do so.

To nominate a team physician, contact the ISMS Division of Medical Services at 312/782-1654 and request an application. You will be asked to complete and return the application with nomination back-up information regarding evidence of the physician's dedication to athletics and the community, such as information on the nominee's school, sports team activity, community activities and educational programs conducted.

Once the ISMS Sports Medicine Committee receives an application, the team physician is considered a nominee. The committee will contact the school and the physician's county medical society to assist in the selection process. All nominators will be notified of the selected physicians. Nominations submitted but not chosen the previous year will be considered for the 1984 awards. ◂

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

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Guide to Continuing Medical Education

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

NOVEMBER

Cardialagy

Congestive Myocordiopothy
For: GP's, FP's. Seminar, Nov. 10, 2:00 p.m., Urbono. **Sponsor:** Corle Foundotion Hospitol, 602 West University Ave., Urbono 61801. **Reg. deodline.** 11/3. **Fee:** $35. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contoct:** Deboroh Rugg. **Phone:** 217/337-3022.

Cardiology

Current Cordiology
For: Internists, FP's, GP's. Lecture, Nov. 28-Dec. 1, Chicago. **Speaker:** Stuort Rich, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $310. **Reg. limit:** 90. **Credit:** Category 1, 22 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Chemical Dependence

Office & Hospital Treotment of Chemicol Dependence
For: Psychiotrists, Internists, GP's, FP's. Lecture, Nov. 7-9, Chicago. **Speaker:** Froncois Alouf, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicago 60612. Fee: $280. **Reg. limit:** 55. **Credit:** Category 1, 20 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Internal Medicine

Advances in Internol Medicine
For: Internists. Lecture, Nov. 14-18, Chicago. **Speaker:** Sheldon Woldstein, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390. **Reg. limit:** 90. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Medicine

Antibiotic Usage
For: Surgeons, FP's. Symposium, Nov. 8, 7:00 p.m., Effinghom. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $40. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Pain

Management of Pain
For: MD's. Symposium, Nov. 3, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Pain

Poin Conference
For: MD's. Symposium, Nov. 18-19, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed; AOA. **Contact:** Soroh Aslokson. **Phone:** 608/263-2856.

Pathalagy

Urologic Pothology & Radiology
For: Urologists, Pothologists, Radiologists. Lecture, Nov. 28-Dec. 2, Chicago. **Speaker:** Thomas John, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 55. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Pathalagy

Visiting Clinician in Surgical Pathology
For: Pathologists. Course, one or two weeks (year-round), Chicago. **Sponsor:** The University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. Fee: $440/wk. **Credit:** Category 1, 40 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Pathalagy

The AIDS Problem
For: Pathologists. Lecture, Nov. 14, 7:00 p.m., The Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospitol, 645 S. Central Ave., Chicago 60644 **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 × 5720.

Pathalagy

Surgical Pathology of the Lung and Related Lesions of the Mediastinum
For: Pathologists. Course, Nov. 14-17, Chicago. **Sponsor:** American Society of Clinicol Pathologists, 2100 W. Harrison St., Chicago 60612. **Fee:** $500, members; $600, nonmembers. **Reg. limit:** 60. **Credit:** Category 1, 24 hours. **Contact:** Barb Agustin. **Phone:** 312/738-1336 × 188.

Plastic Surgery

Management of Upper Extremity Injuries
For: MD's. Symposium, Nov. 12, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. limit:** 150. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/367-9673.

Respiratary

Respiratory Critical Core Symposium
For: MD's. Symposium, Nov. 3-4, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** $210; $125, resident. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed; AOA. **Contact:** Soroh Aslokson. **Phone:** 608/263-2856.

Surgery

Fiberoptic Esophogogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, Nov. 14-16, Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Flexible Fiberoptic Sigmoidoscopy
For: Abdominol Surgeons, Internists, Gastroenterologists. Lecture, Nov. 19, Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $125. **Reg. limit:** 60. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

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DECEMBER

Clinical Medicine

Computers and Clinical Medicine
For: MD's. Symposium, Dec. 1, 1:00 p.m., Sparta. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Gerontology

Progmatic Clinicol Gerontology
For: MD's. Symposium, Dec. 7, Chicogo. **Sponsor:** IMMG-Worren Borr Povilion of Illinois Mosonic Medicol Center, 66 W. Oak St., Chicogo 60626. **Reg. deodline:** Nov. 1. **Fee:** none. **Reg. limit:** 100. **Credit:** Cotegory 1, 8 hours; AAFP Prescribed, 8 hours. **Contact:** Bertrom Moss, MD. **Phone.** 312/337-5400 × 268.

Heart Diseose

Diognosis & Monogement of Myocordiol Infarction
For: MD's. Symposium, Dec. 9-10, Modison, WI. **Sponsor:** U of Wisconsin—Extension, CME, 465b WARF Bldg., 610 Wolnut St., Modison, WI 53705. **Fee:** $160. **Reg. limit:** none. **Credit:** Category 1, 10 hours; AAFP Prescribed, 9½, opplied for: AOA, 10 hours. **Contact:** Soroh Aslokson. **Phone:** 608/263-2856.

Medicol Educotion

Applications of Problem-Bosed Learning in Pre-Clinical Disciplines
For: MD's. Workshop, Dec. 5-8, Corbondole. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springifeld 62708. **Fee:** yes. **Reg. limit:** yes. **Credit:** Cotegory 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Medicine Grond Rounds
For: MD's. Lecture, Wednesdoys, 11:00 a.m. **Sponsor:** Dept. of Medicine, UHS/The Chicogo Medical School, 3333 Green Boy Rd., North Chicogo 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Cotegory 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Medicine

Environmentol Medicine
For: Internists, GP's, FP's. Lecture, Dec. 5-9, Chicago. **Speokers:** Stephen Greenberg, PhD; Emerson Doy, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $370. **Reg. limit:** 90. **Credit:** Cotegory 1, 30 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Neurology

Clinical Neuroimmunology
For: Neurologists, Psychiotrists, Immunologists. Course, Dec. 7-9, Chicogo. **Sponsor:** University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. **Fee:** NA. **Reg. limit:** none. **Credit:** Cotegory 1, 18 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Neurology

Neurology for the Non-Neurologist
For: Internists, FP's, GP's, Psychiatrists, Rehob. Medicine. Course Review, Dec. 7-9, Chicogo. **Sponsor:** Rush University, CME, 600 S. Poulino, Chicogo 60612. **Fee:** $350. **Reg. limit:** none. **Credit:** Category 1, 20 hours; AAFP opplied for. **Contact:** Barbora Trejo. **Phone:** 312/942-7095.

Ob-Gyn

Problem Solving in Gynecologic Endocrinology and Infertility
For: MD's. Course, Dec. 9-10, Chicogo. **Sponsor:** University of Chicago, CME, 950 E. 59th St., Box 139, Chicago 60637. **Fee:** $195. **Reg. limit:** none. **Credit:** Cotegory 1, 11 hours; ACOG, 11 cognotes. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Ob/Gyn

Outpatient Gynecology
For: GP's, FP's. Seminor, Dec. 3, o.m., Urbano. Sponsor: Carle Foundotion Hospital, 602 W. University, Urbana 61801. **Reg. deodline:** 11/25. **Fee:** $35. **Credit:** Cotegory 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Deborah Rugg. **Phone:** 217/337-3022.

Pothology

Modren Serology Loborotory, Selected Topics ond Applicotion
For: Pathologists. Lecture, Dec. 12, 7:00 p.m., Chicogo. **Sponsor:** Chicago Pothology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Reg. deodline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Cotegory 1, 2 hours.

Rodiology

Visiting Fellowships in Diognostic Rodiology
For: Radiologists. Course, one or two weeks (yeor-round), Chicago. **Sponsor:** University of Chicogo, 950 E. 59th St., Box 139, Chicago 60637. **Fee:** $450 per week. **Credit:** Cotegory 1, 40 hours. **Contact:** Mory Ann Dillon. **Phone:** 312/962-1056.

Thorocic Surgery

Speciolty Review in Thoracic Surgery
For: Surgeons. Lecture, Dec. 5-10, Chicago. **Speoker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. limit:** 20. **Credit:** Cotegory 1, 48 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

JANUARY

Internol Medicine

Medicol Seminar-at-Sea
For: MD's. Seminor, Jan. 8-19, Caribbeon Sea. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. deodline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Cotegory 1, 48 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Surgery

Specialty Review in General Surgery, Port II
For: generol ond speciolizing surgeons. **Lecture,** Jan 23-Feb. 2, Chicogo. **Speaker:** Robert Boker, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $675. **Credit:** Category 1, 100 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

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President's Page



Scholarly Activity and Your Medical Journal

Publication of the intellectual pursuits of the membership in a refereed journal is one function of an organization's literary organ. The *Illinois Medical Journal* serves this purpose, among others, for the membership of the Illinois State Medical Society. Its content can serve as a timely presentation of scientific information presented by the clinician as he provides care for his patients with the traditional intellectual curiosity of members of this profession.

Elsewhere in this issue in the "Membership Forum" column, you will see a letter to the editor commenting on the timeliness of the physician's case report.* It points out an observation that, in addition to our own publication, the clinical entity was subsequently addressed in other publications of national distribution.

I join the editors of the *Illinois Medical Journal* in drawing the attention of the membership to the significance of publishing their case reports and review manuscripts as a means of sharing information about events of national significance in the literature.

Although some may believe that all significant information flows from this country's periphery to the middle, we can assure them that the prairies of the Midwest, with their fertile resources, provide a vital component in the scientific investigation carried out by the medical profession that is well beyond our railsplitting heritage. ◀

Robert P. Johnson, M.D.

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("The Home Field Advantage," page 402—Ed.)*

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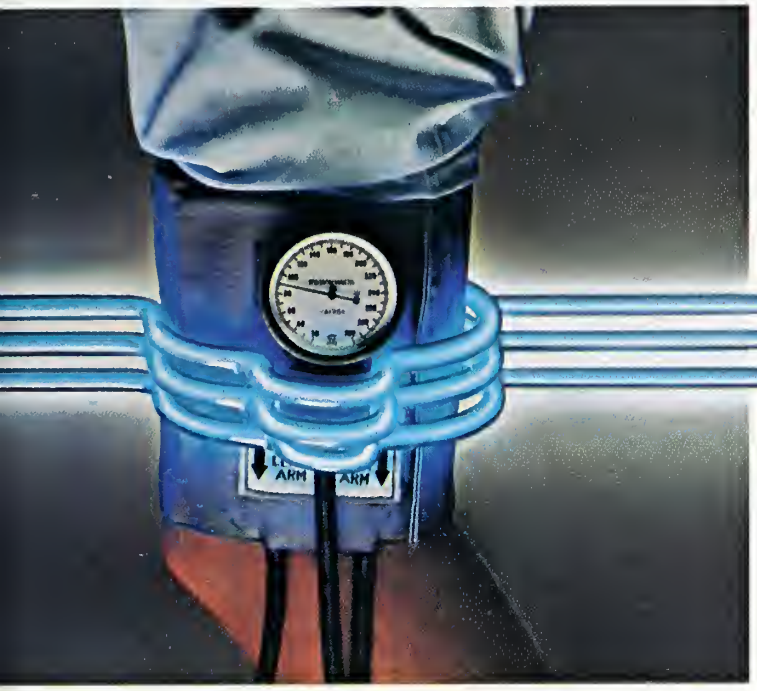
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The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis; erythematous rash, fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8688/883

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Guest Editorial

Prison Medicine

In today's climate of citizen criticism and attack on medicine as well as accusations of inadequate prisoner health care, the paper entitled "A Systematic Approach to Prison Health Care" in this issue is thought provoking and timely. The paper presents an interesting method of meeting the needs of prison health care. Certainly there are other solutions. A comparison of previous methods and other answers to the suggested one in operation at Pontiac would be helpful.

Also, not mentioning other basic reasons for physician reluctance to work in correctional institutions does a disservice. If to all the other disadvantages we add the uncertainties of policy inherent in changing political climates, job insecurity, and sometimes narrow dictatorial leadership, then we realize why physicians avoid such positions even when their interest, compassion and medical backgrounds might otherwise direct them to help. Certainly there are other factors.

Have you anything to add to these suggested means to improve prison health care? Send us your criticisms or ideas.

Eli L. Borkon, M.D., Carbondale

Member, *IMJ* Editorial Board

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

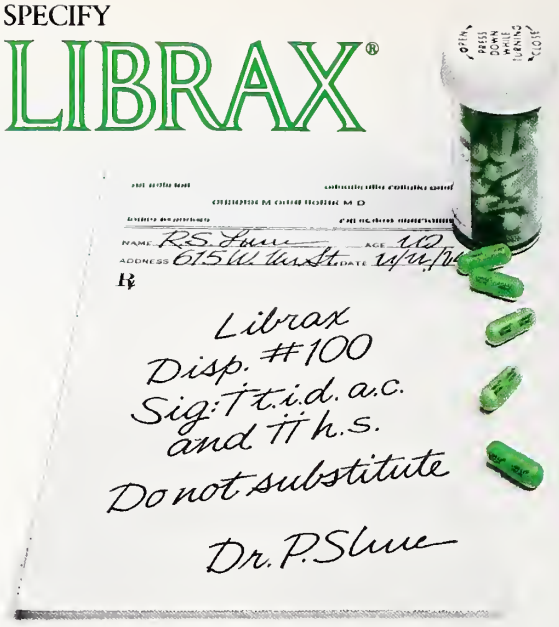
Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal,* however, will secure author permission before authorizing a reprint.

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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*Librax has been evaluated as possibly effective adjunctive therapy in the treatment of irritable bowel syndrome and duodenal ulcer. Please see summary of prescribing information on the preceding page.

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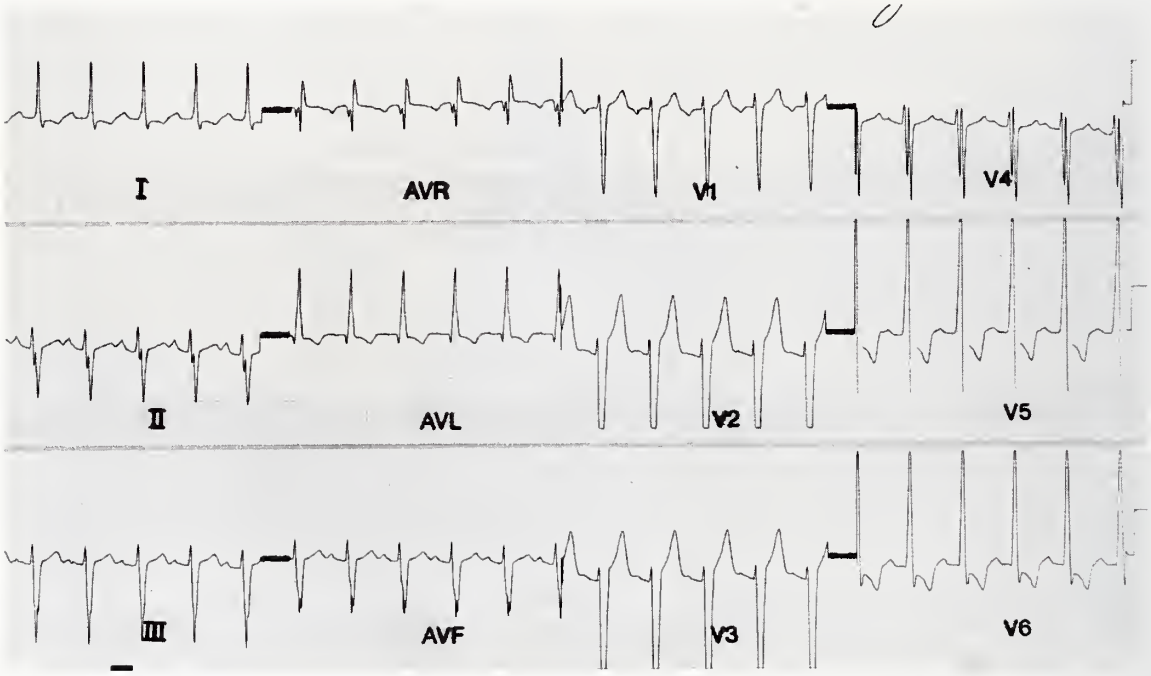
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EKG of the Month

CONTRIBUTING EDITORS: JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D., JOHN R. TOBIN, M.S., M.D., ROLF M. GUNNAR, M.S., M.D., AND PATRICK J. SCANLON, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This patient is a 48 year old Indian male who was known to have a heart murmur for nine years. There was no history of acute rheumatic fever. His condition had slowly worsened over the nine years. Now he developed dyspnea on exertion after walking 50 yards. He planned to come to the United States for a second opinion. Shortly after arrival here, he was admitted through the emergency service in acute pulmonary edema. Rales were present throughout both lung fields. His blood pressure was 130/50mmHg and his pulse was 120 beats per minute with "water hammer" quality. His precordium was active and diffuse with the point of maximum impulse in the mid axillary line. A palpable and audible ventricular gallop was present. A grade ¾ diastolic high frequency, blowing murmur was heard at the left lower sternal border. A chest X-ray was compatible with pulmonary edema and showed cardiomegaly. This twelve lead ECG was obtained.



Questions:

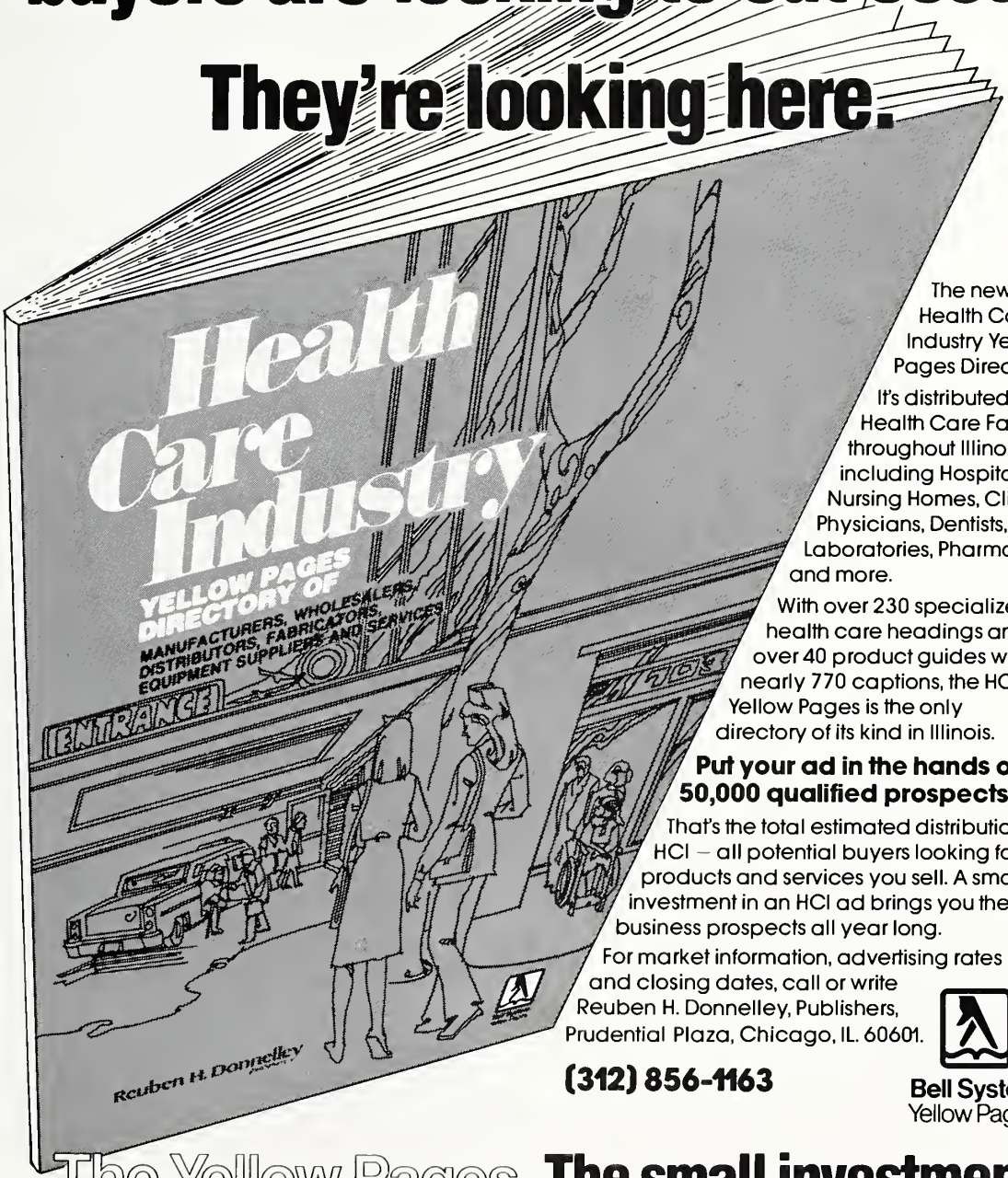
1. **The twelve lead ECG shows:**
   - A. The Wolff-Parkinson-White syndrome or pre-excitation.
   - B. Left axis deviation or left anterior hemiblock.
   - C. Left atrial enlargement.
   - D. Severe left ventricular hypertrophy.
   - E. Complete left bundle branch block.

2. **Management of this patient could include:**
   - A. Swan-Ganz catheterization of the pulmonary artery.
   - B. Digoxin and diuretics.
   - C. Nitroprusside infusion and/or hydralazine.
   - D. Valve replacement surgery.
   - E. All of the above.

(Continued on page 398)

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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

December 5	ANCHOR	Chicago
December 6	Illinois Interagency Council on Smoking & Disease	Chicago
January 3	Illinois Interagency Council on Smoking & Disease	Chicago
January 10	Northwestern Memorial Hospital	Chicago
January 17	Carle Clinic Assn & ACS	Urbana
February 1	Illinois Interagency Council on Smoking & Disease	Chicago
March 6	Northwestern Memorial Hospital	Chicago
March 6	Illinois Interagency Council on Smoking & Disease	Chicago
April 3	Illinois Interagency Council on Smoking & Disease	Chicago
May 1	Northwestern Memorial Hospital	Chicago
May 1	Illinois Interagency Council on Smoking & Disease	Chicago
June 5	Illinois Interagency Council on Smoking & Disease	Chicago

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nitedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCAROIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCAROIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCAROIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCAROIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCAROIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCAROIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCAROIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCAROIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCAROIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nitedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCAROIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

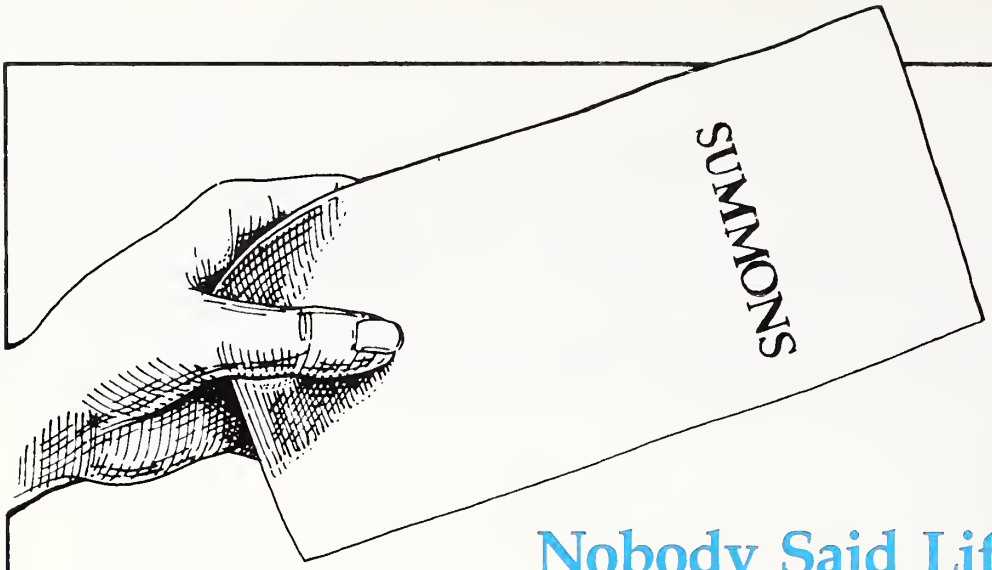


for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

rocardia is indicated for the management of:
Confirmed vasospastic angina.
Angina where the clinical presentation suggests a possible asospastic component.
Chronic stable angina without evidence of vasospasm in atients who remain symptomatic despite adequate doses of eta blockers and/or nitrates or who cannot tolerate these gents. In chronic stable angina (effort-associated angina) ROCARDIA has been effective in controlled trials of up to ght weeks' duration in reducing angina frequency and creasing exercise tolerance, but confirmation of sustained fectiveness and evaluation of long-term safety in these atients are incomplete.

Please see PROCARDIA brief summary on adjoining page.



Nobody Said Life Was Fair!

Life hasn't been fair to physicians lately. Skyrocketing malpractice claims and whopping damage awards have caused premiums for malpractice insurance to soar.

Like other insurers, the Illinois State Medical Inter-Insurance Exchange has not been immune to rising professional liability costs, and premiums have had to be increased accordingly. At the same time, the Exchange — through its physician ownership — is constantly striving to maintain reasonable and equitable insurance premiums by making appropriate changes in its underwriting program.

That's why the Exchange has undertaken the most comprehensive restructuring of its professional liability program since 1977. Many revisions have been made for the 1983-84 program year — including creation of a lower risk classification and a third rating territory which will provide some physicians with premium reductions.

Illinois counties that have favorable loss experience have been assigned lower rates. Based on loss experience data pertaining to specialty and procedures performed, the Exchange was able to further refine its underwriting program to more accurately reflect practice exposures.

The Exchange is dedicated to maintaining a viable, responsive and fiscally sound insurance program for the long-term benefit of its members. We will continue to make revisions in our professional liability program as evidence of our commitment to provide Illinois physicians with the best professional liability protection available in the most equitable manner possible.

Physician Ownership Makes a Difference!

Illinois State Medical
Inter-Insurance Exchange

Administered by

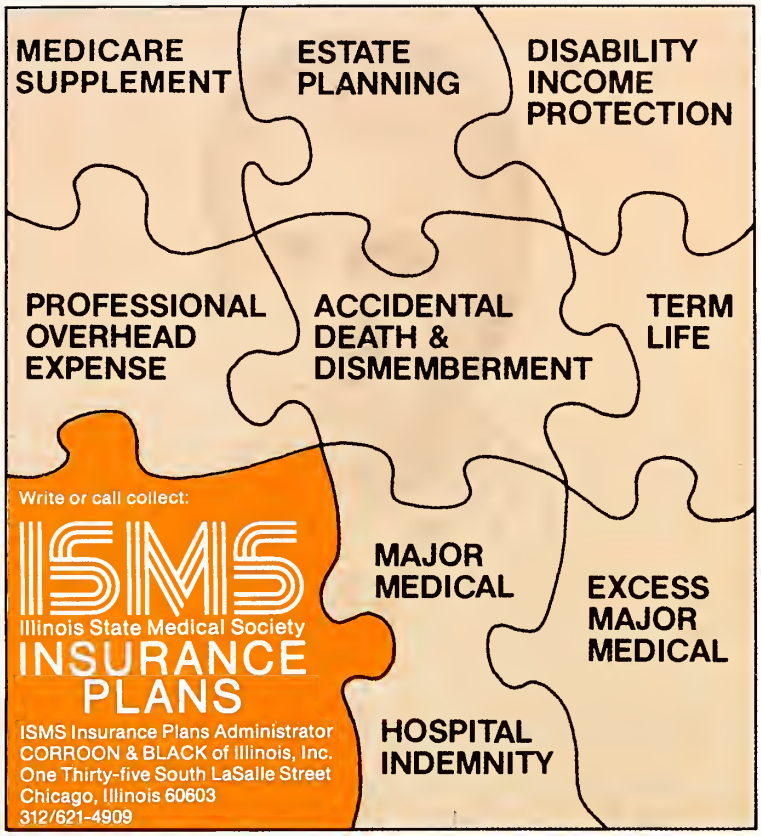
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SOLVE YOUR PROTECTION PUZZLE

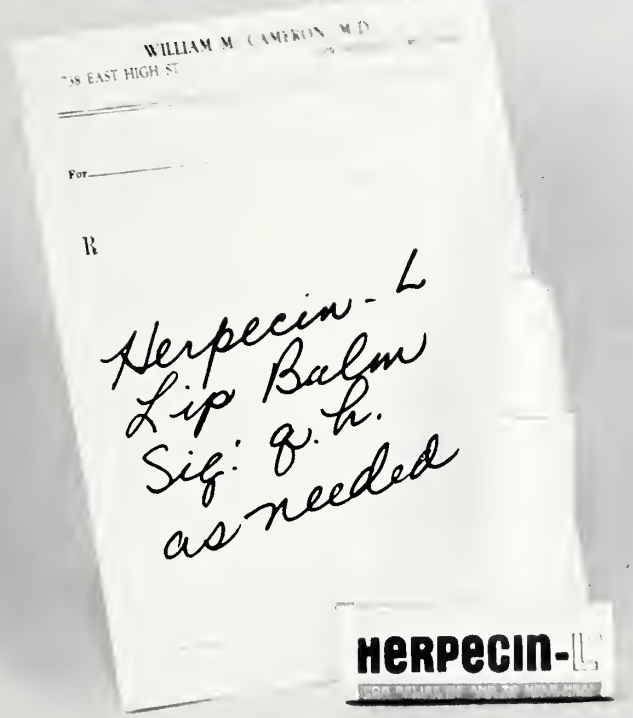
The insurance puzzle... are there pieces missing from your picture?

As a member of ISMS, you can realize substantial benefits by participating in society-approved insurance plans. Designed and administered by professionals in cooperation with ISMS, this program could be the answer to your personal and professional needs. While your requirements receive individual attention, you also enjoy the economies of ISMS group purchasing power.

COMPLETE PROGRAM PROFILE OFFERED WITHOUT OBLIGATION



Dx: recurrent herpes labialis



"Herpecin-L Lip Balm is **the treatment of choice** for peri-oral *herpes.*" GP, New York

"In the management of *herpes labialis,* Herpecin-L is a **conservative approach** with **low risk / high benefit.**" Derm., Miami

"Staff and patients find Herpecin-L remarkably **effective.**" Derm., New Orleans

OTC. See *P.D.R.* for information. For trade packages to make your own clinical evaluation, write: CAMPBELL LABORATORIES INC. P.O. Box 812-M, FDR, NY, NY 10150

In Illinois, "HERPECIN-L" Cold Sore Lip Balm is available at all *Medicare, Osco, Revco* and *SupeRx Drug Stores* and other select pharmacies.

Abstracts of Action

September 24, 1983

Palmer House
Chicago, Illinois

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

PEER REVIEW ORGANIZATION (PRO)

At its June meeting, the Board of Trustees established an Ad Hoc Committee on PRO. This committee was charged with monitoring and reviewing the development and implementation of the PRO regulations and to identify activities being undertaken by groups seeking designation as the PRO in Illinois. The ad hoc committee developed a report which was presented to the Executive Committee. Based upon a full review of the proposed regulations and after receiving comments from Illinois County Medical Societies, Foundations and PSROs, the Executive Committee directed action to respond to the proposed rulemaking prior to the September 14 deadline.

Subsequently, upon the recommendation of the Executive Committee and after review of a research paper pertaining to PRO, the Board adopted the following positions:

- That ISMS not seek designation as a statewide PRO.
- That ISMS seek dual PRO designation for Illinois and provide a resource capacity to physician organizations seeking designation.
- That should Illinois be designated a single PRO area, ISMS act in a resource capacity to assist existing physician review organizations to apply for designation as the statewide PRO.

In addition, a discussion session will be scheduled at the Leadership Conference November 12-13, to address current events pertaining to PRO.

PROFESSIONAL LIABILITY INITIATIVES

In response to the current professional liability climate, various action options have been identified and explored by the Executive Committee. These activities were undertaken with the recognition that an impending crisis of affordability may soon be upon physicians, due to an escalating number of claims and awards in allegations of negligence.

Three options were developed and reviewed. Option one would cause development of a comprehensive legislative package plus a policy holder survey to determine the breadth and depth of members' feeling commitment in this arena. The second option included both a public opinion poll and a media campaign. If option three were also undertaken an advisory public referendum would be accomplished. These options were also reviewed by the ISMIS Board of Directors and the ISMIE Executive Committee.

The Board adopted option one, deferring action on options two and three pending results of the policyholder survey. In addition, the Board directed that ISMIE be asked to consider funding of option one of the Professional Liability Initiatives.

(Continued on page 434)

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride
(80 mg, 120 mg, 160 mg Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE
At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. **8511/783**

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Obituaries

***Bowser, F. Keith,** Joliet, died September 17, 1983 at the age of 64. Dr. Bowser was a 1950 graduate of the University of Kansas School of Medicine, Kansas City.

****Burdick, Allison L., Sr.,** died September 19, 1983 at the age of 89. Dr. Burdick was a 1922 graduate of Rush Medical College, Chicago. The former Chicago Medical Society president (1963 and 1964) practiced medicine for 60 years. Dr. Burdick was also a former vice-president of ISMS. He was a family physician on Chicago's North Side and was on the staff at West Surburban Hospital, Oak Park. Dr. Burdick is survived by a son, Dr. Allison Burdick, Jr., four grandchildren and five great-grandchildren.

***Forman, Jerome,** Bradenton, Florida, died September 24, 1983 at the age of 65. Dr. Forman was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

***Geyser, Frederick P.,** Pompano Beach, Florida, died September 9, 1983 at the age of 73. Dr. Geyser was a 1953 graduate of State University of New York, Upstate College of Medicine, Syracuse.

***Impastato, Frank,** Mount Prospect, died September 7, 1983 at the age of 76. Dr. Impastato was a 1936 graduate of the Loyola University Stritch School of Medicine.

****Johnson, Edward M.,** Chicago, died September 13, 1983 at the age of 88. Dr. Johnson was a 1923 graduate of Howard University College of Medicine, Washington.

***Katty, Virupax S.,** Belleville, died August 15, 1983 at the age of 58. Dr. Katty was a 1950 graduate of the University of Bombay, India.

****Levine, David A.,** Sarasota, Florida, died June 19, 1983 at the age of 89. Dr. Levine was a 1919 graduate of Rush Medical College, Chicago.

****Rogers, Maurice P.,** Rockford, died September 7, 1983 at the age of 90. Dr. Rogers was a 1916 graduate of Rush Medical College, Chicago.

***Schroeder, Helen Willner,** River Forest, died September 25, 1983 at the age of 61. Dr. Schroeder was a 1948 graduate of the University of Illinois College of Medicine, Chicago.

****Segal, Samuel, Jr.,** Virginia Beach, Virginia, died August 26, 1983 at the age of 88. Dr. Segal was a 1917 graduate of Tufts University School of Medicine, Boston.

***Swansbro, William J.,** Danville, died September 1, 1983 at the age of 61. Dr. Swansbro was a 1948 graduate of the University of Wisconsin Medical School, Madison.

****Tremaine, Myron J.,** Chicago, died September 29, 1983 at the age of 77. Dr. Tremaine was a 1933 graduate of Northwestern University Medical School, Chicago.

***Walsh, William S.,** Chicago, died September 18, 1983 at the age of 79. Dr. Walsh was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

***White, Harvey,** Evanston, died Septemter 15, 1983 at the age of 67. Dr. White was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

Willrich, Karl, Evanston, died September 3, 1983 at the age of 56.

****Woodruff, Lewis,** Tuscon, Arizona, died July 15, 1983 at the age of 82. Dr. Woodruff was a 1927 graduate of Rush Medical College, Chicago.

**Indicates ISMS member.*
***Indicates member of ISMS Fifty Year Club.*

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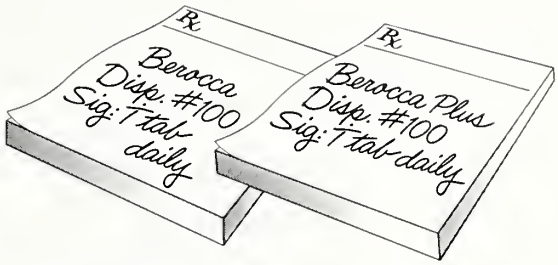
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Mariann M. Stephens, Managing Editor

Rx ONLY **Berocca® Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

also available as Rx ONLY **Berocca®** TABLETS



Before prescribing, please consult complete product information, a summary of which follows:

Each Berocca® tablet contains: 500 mg vitamin C (ascorbic acid), 15 mg vitamin B_1 (as thiamine mononitrate), 15 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 4 mg vitamin B_6 (as pyridoxine HCl), 18 mg pantothenic acid (as calcium *d*-pantothenate), 0.5 mg folic acid, 5 mcg vitamin B_{12} (cyanocobalamin).

Each Berocca® Plus tablet contains: 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha-tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

INDICATIONS: Berocca—Supportive nutritional supplementation in which water-soluble vitamins are required prophylactically or therapeutically, including conditions causing depletion, or reduced absorption or bioavailability of water-soluble vitamins, conditions resulting in increased needs for water-soluble vitamins. Berocca Plus—Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, vitamin D and calcium supplementation may be required with Berocca Plus or supplementation with fat-soluble vitamins and minerals may be required with Berocca. Not intended for treatment of severe specific deficiencies. *Information for the Patient.* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease efficacy of levodopa in treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca and Berocca Plus. Allergic and idiosyncratic reactions are possible at lower levels. Iron, even at recommended levels, has been associated with GI intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Available on prescription only. (Berocca Plus is not recommended for children.)

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1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1114.

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EKG

(Continued from page 380)

Answers: 1. B, C, D 2. E

Several of the numerous criteria for left ventricular hypertrophy are seen here: R in lead I + S in lead III greater than 25mm, R in lead AVL greater than 11mm, R in lead V_5 greater than 25mm, S in lead V_1 + R in lead V_5 or V_6 greater than 35mm. The QRS duration is slightly prolonged to 0.11 seconds with a notch in the mid QRS. This could represent a prolonged ventricular activation time or an early conduction defect but the QRS duration is too short for a diagnosis of complete left bundle branch block. The PR interval is 0.15 seconds so no pre-excitation of the ventricles is present. The QRS axis is leftward to approximately −45° suggesting left anterior hemiblock. As an isolated finding, left axis deviation is a poor sign of left ventricular hypertrophy. Left anterior hemiblock caused by left ventricular fibrosis is a more likely cause of the left axis deviation. The negative P wave in lead V_1 contains the area of approximately one small box on the ECG and suggests left atrial enlargement. Although this patient has severe volume overload of the left ventricle (LV) caused by aortic regurgitation, there are no ECG signs of that. This patient was already taking digoxin and furosemide when he arrived in pulmonary edema. Pulmonary artery and pulmonary capillary wedge pressures were elevated significantly. Both nitroprusside infusion and hydralazine were required to keep the "wedge" pressure down and control the congestive heart failure by reducing the preload and the afterload of the LV. On all these medications, a radionucleotide blood pool scan demonstrated an ejection fraction of 19%. An M-mode echocardiogram confirmed the dilated chambers with an end systolic LV dimension of 68mm and a LV fractional shortening of less than 10%. Cardiac catheterization confirmed the severe aortic regurgitation and showed normal coronary arteries. An urgent aortic valve replacement was performed. Several studies now confirm the concept that valve replacement should be offered to patients with chronic severe aortic regurgitation and left ventricular dysfunction. Our patient survived the valve surgery and is doing fairly well at six months follow-up. ◀

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Doctor's News

ERRATUM—It has come to our attention that an error appears in the October *IMJ* "1983 Officers Of County Medical Societies" entry for Cook County (page 297).

As reported correctly in the September issue, **Dr. Harry A. Springer,** Evanston, is the current president of the Chicago Medical Society. **Dr. Alfred J. Clementi,** Arlington Heights, who is erroneously listed as president, completed his term of office on June 29, when he installed Dr. Springer as 1983-84 president.

Dr. Springer is a board certified plastic surgeon who also holds a D.D.S. degree from the Dental School of Northwestern University. He is both a member of the ISMS Board of Trustees and an alternate delegate to the AMA.

The editors regret the error.

PHYSICIANS IN THE NEWS—**Adolf Faller, M.D.,** Calumet City, received an inscribed Abbott Golden Timepiece in recognition of his 50th anniversary in medical practice.

Herman Levy, M.D., Hollywood Park, was honored for his 50th anniversary as a physician by the Bethany Methodist Hospital, Chicago, where he has served since 1949. Dr. Levy is also a member of the ISMS Fifty Year Club.

Enayat Osanloo, M.D., Naperville, has been elected to fellowship in the American College of Physicians.

Richard Wallyn, M.D., was recently named to the board of directors of the Heart Association of South Cook County.

SPORTS MEDICINE SYMPOSIUM—The University of Iowa Sports Medicine Services and the College of Medicine are co-sponsoring the Hawkeye Sports Medicine Symposium, January 5-7, 1984 at the Iowa Memorial Union, the University of Iowa Campus, Iowa City.

The program will present an overview of current medical practice recommendations for the care and prevention of common sports related injuries and illnesses. For further information contact Deborah Long Hatz, program assistant, The University of Iowa College of Medicine, Office of Continuing Medical Education, Iowa City, Iowa 52242.

NEW EMERGENCY ROOMS—The University of Chicago Medical Center has opened two new emergency rooms in the Center's new 468-bed replacement hospital. The new emergency rooms, one for adults and one for children, replace the emergency rooms at Billings Hospital and Wyler Children's Hospital. The emergency care center is believed to be the only one in the Chicago area with a decontamination suite to isolate and treat patients contaminated by toxic chemicals or radioactive materials.

FUND RAISING IDEA: BIG LOSERS WIN—The American Diabetes Association's checkbook grew as celebrity team members lost weight during a recent fundraiser sponsored by G.D. Searle & Co., Skokie. The sponsor offered $200 per pound lost by each member of the winning celebrity team. After all donations were tabulated at $30,000, the donation was "rounded" to $50,000.

ACP ANNUAL SESSION—The American College of Physicians (ACP) will hold its 65th annual session at the Georgia World Congress Center, in Atlanta, April 26-29, 1984. The four day event will feature over 240 physicians who will present about 330 sessions on the current ideas, procedures and developments in internal medicine. For more information contact ACP at 4200 Pine Street, Philadelphia, PA 19104.

MATERNAL AND CHILD HEALTH TRAINING—The Graduate School of Public Health, San Diego State University, San Diego, California is accepting applications from obstetricians, pediatricians and other physicians interested in a career in maternal and child health. Applications are being accepted for the August 1984 training program. The master of public health degree is awarded for this nine-month program. Send inquiries to: Helen M. Wallace, M.D., professor and head, Division of Maternal and Child Health, Graduate School of Public Health, San Diego State University, San Diego, CA 92182.

U.S.-CANADIAN PATHOLOGY CONFERENCE—The Annual Meeting of the United States-Canadian Division of the International Academy of Pathology will be held at the San Francisco Hilton in San Francisco, California, Monday, March 12 through Friday, March 16, 1984. The program will include scientific papers, poster sessions, 12 specialty conferences and 44 short courses. For further information contact Dr. Nathan Kaufman, secretary-treasurer, United States-Canadian Division of the International Academy of Pathology, 1003 Chafee Avenue, Augusta, Georgia 30904 or call (404) 724-2973.

CARDIOLOGY FELLOWSHIP AWARDS DEADLINE—The deadline for the 1984-85 Adult Cardiology Fellowship Training Awards is January 1, 1984. The Fellowship, offered by the American College of Cardiology (ACC) and The Merck Company Foundation, will provide a $20,000 stipend and an additional $5,000 for the cost of supplies. Applicants must be in their first or second year of adult cardiology fellowship training. The Merck Fellow of the American College of Cardiology is expected to complete a clinically-oriented project during the year of training. For more information contact: ACC, 9111 Old Georgetown Road, Bethesda, MD 20814.

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Membership Forum

Membership Forum is intended to serve as a communication tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

On Risks In Diagnostic Radiation

Dear Sir:

The "Viewbox" feature in the January, 1983, issue of the *Illinois Medical Journal,* (163:1,p.12) having as its subject the risks of radiographic examinations in a possibly pregnant woman, was in my opinion well done and very timely.

Readers of the *Illinois Medical Journal* should know that there is a rather complete AMA report on the subjects of low-level ionizing radiation and nuclear energy. Among others, the report considers how reactors generate electricity; average annual exposures to ionizing radiation of medical workers and the public; effects of ionizing radiation in the individual; risks of generating electricity with nuclear energy; and environmental aspects. Also, the report lists more than 60 authoritative references and includes a glossary of terms and definitions.

The report is available at a cost of $4.50 from the AMA Order Department, PO Box 10946, Chicago, IL 60610. A summary of the report appears in JAMA, November 13, 1981, on pages 2161-2162.

Sincerely yours,
Theodore C. Doege, M.D., M.S.
Hinsdale

The Editor Replies:

I appreciate Dr. Doege's kindness in writing to provide additional research material on diagnostic radiation risks, particularly as pertinent in pregnancy. I would encourage our readers to pursue the document referred to in his letter, as well as the additional references on that topic which were published with the article on page 66 of the January, 1983, issue.

Terrence C. Demos, M.D.
Contributing Editor

The Home Field Advantage

Dear Dr. Roddick:

I realize this is out of your field, but I thought you might be interested knowing that the *Illinois Medical Journal* was publishing case reports that are of considerable topical interest and up-to-date (Moses, H.W., Taylor, G.J., Asali, A., Brewer, T.E.: "Coronary Artery Spasm Causing Myocardial Infarction," *IMJ* 163: 4, 265-268, April 1983). This copy of the *New England Journal of Medicine* case report of coronary artery spasm resulting in coronary thrombosis and myocardial infarction (Vincent, G.M., Anderson, J.L., Marshall, H.W.: "Coronary Spasm Producing Coronary Thrombosis and Myocardial Infarction," *NEJM* 309: 4, 220-224, July 1983) is virtually a duplication of a case report published in the *Illinois Medical Journal* a few months ago. The one additional feature that makes this unique is that the patient had the catheterization just prior to the myocardial infarction. In fact, myocardial infarction was provoked iatrogenically during Ergonovine challenge. A similar case to ours was also published in *Circulation* (also published after the case report in the *Illinois Medical Journal*) of a 37-year-old documented to have spasm and clot producing myocardial infarction in the presence of nearly normal coronaries. This is cited in the editorial by Doctor Conti (Conti, C. R.: "Coronary-Artery Spasm and Myocardial Infarction," *NEJM* 309: 4, 238-239, July 1983).

I realize this is not of great interest medically to you, but again, I thought it was of interest that the *Illinois Medical Journal* has "scooped" the national literature in this area.

With kind regards,
H. Weston Moses, M.D.
Springfield

The Liability Lottery An Appeal to Reason

Dear Sirs:

Doctor James Scott's letter in the June *IMJ* is surely a moanful lament sung by all Illinois physicians who pay increasing professional liability premiums, practice wasteful defensive medicine and feel trapped and intimidated by the legal climate as it exists today.

We have no media support; moreover, our publicity is uniformly negative ranging the full variety of coverage from ghost surgery on *Quincy* to insurance fraud on *60 Minutes*. The legislative bodies do not respond because we are not a significant political force; our representatives are lawyers—with significant trial lawyer members—and it is not logical for them to desire any change in the rewarding course which we have allowed our floundering to take us.

Unfortunately, Dr. Scott has outlined this national scandal for the wrong audience. We are all aware of the high quality of the physicians with whom we work. Ironically, the public is also aware of this. The AMA public opinion poll shows clearly: The public *trusts, respects,* and *communicates with* their own personal physicians; it is the profession as a whole which is perceived as malevolent. This makes perfect, albeit distressing, sense considering the image of us seen through the headlines and hidden camera.

The public who trust us as their own personal physicians are precisely the audience who need to hear Dr. Scott's litany of reasons and examples. They need to know why good drugs, like Bendectin, go off the market. They will understand better when told why oral contraceptives are so expensive. They need to know why office visits are expensive—they need to hear that freshly trained, superbly competent physicians must pay five figured premiums before answering their first phone call.

Only these friends of ours—our own patients—can make this a political issue. They are intelligent and they care about how much *they* have to pay for this; they will understand that we are only agents, taking their money and passing it to the insurer who rewards a few lucky winners in the liability lottery.

This obvious message will not be told by the media or by government. We have known it for decades and waited for a saviour to rise and lead, and none has come. When the public hears Dr. Scott's song, big business will hear, and only then will political dancing begin. We can no longer afford to be above open, frank discussion on this disasterous affair with our only friends—our patients.

Sincerely yours,
Joseph M., Purpura, M.D.
Lake Forest

Forgotten Virtues?

Dear Sir:

In your June, 1983 issue, "The Viewbox," page 400, you present a PA chest film, a clinical history suggesting myasthenia gravis, and ask what the next step should be. I believe the correct answer is a lateral film of the chest, which in this instance would have established the diagnosis without the benefit of a more expensive radiologic technique.

Whether or not the thymoma is solid or cystic and whether or not it is invasive does not change the indication for surgical resection. In this age of attempting to reduce medical costs the additional information provided by a CAT scan is more of interest than it is of necessity. I trust that the virtues of a lateral chest film have not been forgotten.

Sincerely yours,
C. Frederick Kittle, M.D.
Chicago

The Editor Replies:

PA and lateral chest radiographs, now as in the past, are the most important means of initially identifying thoracic disease. The patient in the June Viewbox had an invasive thymoma visible on the PA chest (Fig. 1). He had a lateral view, not shown, which confirmed this but did not show the extension to vessels or pleura which were identified by CT (Fig. 2). In addition to an abnormal mediastinum, hilus and lung, the patient had diplopia clinically. Myasthenia gravis with an invasive thymoma is the most likely diagnosis, but other neoplasms and even thyroid disease can also be associated with neuromuscular signs. The diagnosis was not certain.

If it is assumed that the diagnosis was invasive thymoma, surgery is indicated. What then would be the value of a CT study? As Dr. Kittle states, this is the age of attempting to reduce medical costs which now exceed 10% of our gross national product. CT must provide unique information or be cost effective to be warranted.

Some thoracic surgeons would operate on a patient with an invasive thymoma straightaway. Thoracic surgeons at this medical center, along with those from the UCLA medical center and Johns Hopkins hospital, however, feel that preoperative CT promotes optimum patient management.[1,2] CT is superior to conventional studies, not only in the diagnosis of mediastinal disease, but in displaying the full extent of invasive thymoma. Invasion of the mediastinum, pleura, pericardium, lung, chest wall, and vessels undetectable by conventional studies can be graphically displayed by CT. This information can then be used to more accurately stage the neoplasm, plan the surgical approach, identify patients better treated by preoperative radiation or chemotherapy, determine radiation fields, and assess therapeutic response.

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Additional NMR information on page 433

IMJ
Illinois Medical Journal
Volume 164, No. 5, November 1983

The Diagnosis of Alcoholic Liver Disease The Dilemma and a Perspective

By Martin A. Swerdlow, M.D. And
Lokendra N. Chowdhury, M.D., Ph.D./Chicago

The confirmation of alcoholic liver disease is difficult and uncertain. The clinical signs and symptoms, clinical laboratory data and liver biopsy findings are all basically non-specific. A history of chronic alcoholism is also of limited confirmatory assistance since only about one-third of chronic alcoholics develop progressive liver disease and alcoholics can and do develop non-alcohol related liver diseases. Three morphologic markers in liver biopsies were evaluated for their specificity in confirming alcoholic injury to the liver. Pericentral and lobular sclerosis, while characteristic for alcoholic liver disease, occurs in a number of non-alcohol related diseases. Giant mitochondria by light microscopy are a characteristic finding in alcoholic liver disease but are difficult to identify in tissues and occur in only 25-50% of cases. IgA deposition in the liver, in a characteristic continuous pattern, holds the greatest promise for specificity in the diagnosis of alcoholic liver disease.

The specific diagnosis of alcoholic liver disease (ALD) is difficult. It is also of critical importance. The specific diagnosis has therapeutic implications: prognosis for ALD before irreversible changes occur is better than for any other chronic liver disease and ALD is increasing.

Alcoholism is a medical problem with increasingly detrimental impacts on individuals and society. It has been estimated that 10 million Americans suffer from chronic alcoholism. This is probably an underestimation. Cirrhosis of the liver is rapidly becoming a major cause of death and disability in the United States, primarily in urban centers and primarily involving people between 25 and 65 years of age. The majority of cirrhosis in the western world is due to alcoholism; 66% in North and South America, 42% in Europe and only 11% in Asia. Most menacing is the trend that while deaths from cardiovascular disease decreased by 2% in the United States in the years between 1950 and 1974, deaths from cirrhosis rose by an alarming 71.7%.

Alcoholic liver disease occurs among people in every socioeconomic grouping. Popper and colleagues feel that the economically disadvantaged

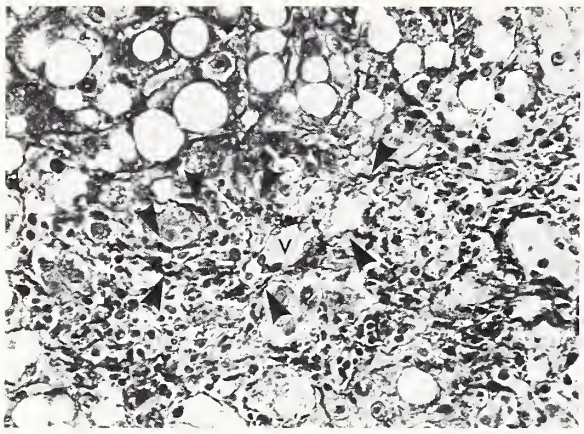


Figure 1
Pericentral and intralobular sclerosis (fibrosis) Mallory trichrome stain (arrows point to collagen fibers around central vein.)

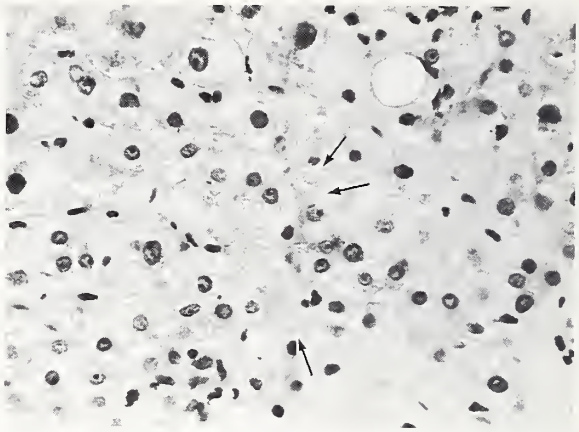


Figure 2
Giant mitochondria Mallory trichrome stain (Arrows point to giant mitochondria in hepatocytic cytoplasm.)

are at greater risk for alcoholic as well as other diseases of the liver.[1] The prolonged high cost incurred by the individual alcoholic patient results more from chronic ALD than from other alcohol related disorders.

The determination of alcohol as the cause of a liver disorder has obvious therapeutic implications. Cessation of alcohol ingestion improves the prognosis in most instances, while continued drinking is often associated with progressive liver disease and a poor prognosis. Inappropriate therapy for misdiagnosed and unrecognized ALD, on the other hand, may have dire consequences. It is clear that the identification of the cause of an injury, particularly alcohol, in the early or precirrhotic stages, is the key to treatment and prevention of irreversible sequelae.

The confirmation of ALD is difficult. Clinical signs and symptoms are generally non-specific, as are clinical laboratory data and data derived from liver biopsy.

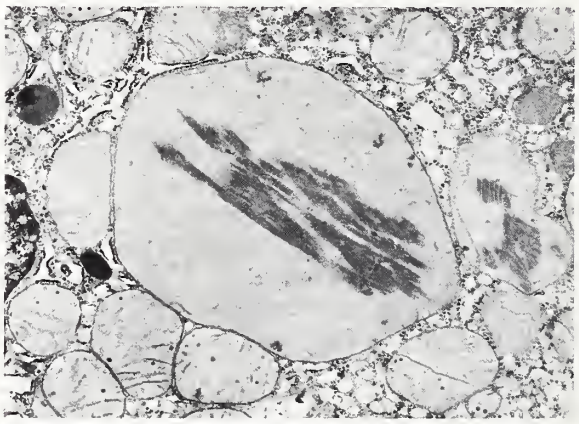


Figure 3
Giant mitochondria. Electron microscopic confirmation.

Clinical Overview

A history of alcoholism, upon which we often base confirmation of the diagnosis, may at times be somewhat less than reliable. In our experience, clinicians do not always seek a history of alcoholism with great diligence. A reliable history of even, heavy (at least 80 grams per day for five years) alcoholic consumption for a prolonged period of time, may in and of itself still not confirm the diagnosis of ALD. No more than one-third of chronic alcoholics appear susceptible to alcoholic injury and develop significant progressive liver disease.[2] Chronic alcoholics, on the other hand, can and do develop non-alcoholic liver diseases to account for liver abnormalities. Indeed they may be at greater risk. Levin[3] and colleagues found that 20%, one of five patients, of a group of chronic heavy drinkers had causes other than ALD to account for their liver abnormalities.

The clinical laboratory data is also generally non-specific with respect to confirming the diagnosis of ALD. In our view, clinical laboratory tests are most useful for establishing the diagnosis of liver disease and for following the course of a patient with liver disease, alcohol or non-alcohol related. The most useful and suggestive laboratory tests, particularly if common non-alcoholic injuries can be excluded, are (1) an increased mean corpuscular volume (MCV), (2) elevated serum IgA, (3) ele-

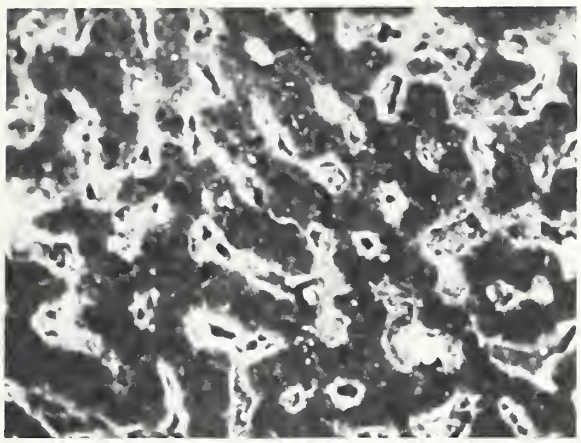


Figure 4
IgA deposition in liver in characteristic continuous pattern. Direct immunofluorescence using formalin fixed paraffin embedded tissues.

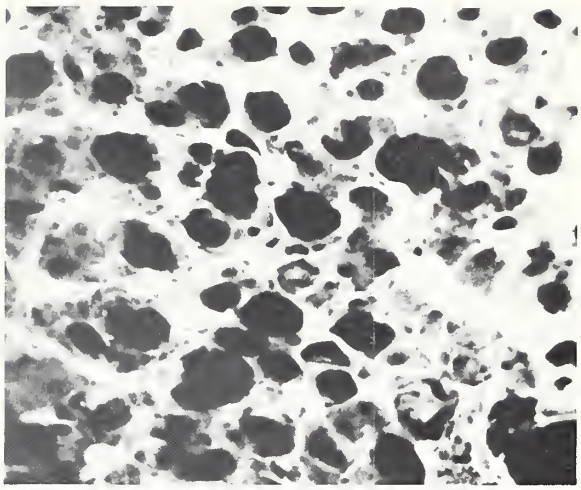


Figure 5
IgA deposition in liver in characteristic pericellular continuous pattern, seen in more active ALD. Direct immunofluorescence, formalin fixed, paraffin embedded tissues.

vated serum gamma glutamyl traspeptidase (GGTP), (4) an elevated serum uric acid, (5) an elevated serum glutamate dehydrogenase (GDH), and (6) aminotransferase levels less than 300 units/100ml with an SGOT:SGPT ratio of greater than 1. Unfortunately there are many exceptions. Clinical laboratory confirmation of ALD is a fertile field for workers in this discipline and there is hope for future developments.

Liver biopsy is generally considered to be the most acceptable method to confirm the diagnosis of ALD.[3] This, too, is less than specific. The liver biopsy in ALD may reveal a broad spectrum of morphologic changes, all of which may be produced by non-alcoholic injuries.

Alcoholic hepatitis, generally considered the most morphologically distinctive and characteristic lesion confirming the diagnosis of ALD, may not always occur with alcoholic injury to the liver.[4] Lesions morphologically identical to "alcoholic hepatitis" are being described with increasing frequency. They can develop in response to a variety of non-alcoholic injuries: obesity, diabetes, post intestinal by-pass surgery, drugs and others.[4,5]

The Mallory body or alcoholic hyalin, described by Mallory in 1911 and thought specific for alcoholic injury, is not always evident in biopsies of ALD.[6] It, too, is being described as occurring in response to a growing list of non-alcoholic injuries: cholestasis, Indian childhood cirrhosis, Wilson's Disease, obesity, diabetes, intestinal by-pass, primary biliary cirrhosis, hepatocellular carcinoma, perhexilene maleate, methotrexate and others.[4,5,7-9] Many observers still contend that Mallory bodies in a predominantly centrolobular location strongly support the diagnosis of ALD.

Methodology

Our goal has been to increase the specificity and unsefulness of the liver biopsy in the confirmation of ALD. We searched for morphologically distinctive markers of ALD[10] and studied three morphological markers to evaluate their specificity in the diagnosis of ALD. These were pericentral and lobular sclerosis (Fig. 1), giant or megamitochondria as seen by light microscopy (Fig. 2) and the deposition of IgA in the liver. The criteria for selection of patients with alcoholic liver disease included those with: (a) a history of alcohol ingestion of at least 80 grams of alcohol per day for at least 5 years; (b) morphologic changes in the liver biopsy consistent with alcoholic injury; (c) clinical laboratory findings consistent with alcoholic injury and (d) no evidence of other liver diseases, absence of viral markers in serum and tissues and no history of drug ingestion.

Pericentral and lobular sclerosis are felt to be characteristic of alcoholic injury.[2,11,12] Van Waes and Lieber[12] feel that pericentral sclerosis is significant in the progressive development of ALD to alcoholic cirrhosis. Nasrallah and colleagues[13] feel that intralobular fibrosis (sclerosis) is more significant as a marker for the progressive development of ALD. While we cannot shed any light on this

controversy, it is our view that pericentral and lobular sclerosis (at times referred to as "creeping collagenosis"), while characteristic for chronic ALD, is not specific for ALD. This opinion is based on a continuing review of liver biopsy and autopsy liver sections stained with the Mallory trichrome stain for connective tissue. Identical patterns are seen in diabetes, non-specific anemia, sickle-cell anemia, chronic passive hyperemia associated with congestive heart failure and a variety of non-specific injuries.[4,13]

Mitochondria, the energy producing intracytoplasmic organelles, are selectively injured by alcohol. Giant or enlarged mitochondria are seen with electron microscopy in a number of diseases,[14] but predominantly in alcoholic liver disease when seen with light microscopy.[15,16] This may be a quantitative phenomenon. We found giant mitochondria in 29 of 58 liver biopsies with ALD and doubtfully in 11 of these 58 biopsies. We have yet to find giant mitochondria with light microscopy in any instance of non-alcoholic liver disease. We have used the Mallory trichrome stain to uncover the giant mitochondria[10] and have confirmed their identity, as have others,[15] (Fig. 3) in a limited sample of cases with electron microscopy. There is general agreement[15,16] that giant mitochondria as seen with light microscopy occurs in 25-50% of cases of ALD.

IgA Deposition

Next, we studied the deposition of IgA in the liver as a specific morphologic marker for ALD.

Elevated serum IgA has been described in ALD but not in nonalcoholic liver disease.[17] Kater and colleagues[18] in Holland studied this with fresh frozen liver tissue and immunofluorescent techniques. They found a characteristic linear continuous pattern of IgA deposition in the liver in 76% of cases of ALD and 6.1% of cases of non-alcoholic liver disease. We[19] have approached this routinely, using formalin fixed and paraffin embedded tissues and standard direct immunofluorescent and immunoperoxidase techniques that can be performed in any laboratory. Our analyses have found this characteristic continuous linear pattern of IgA deposition in 78% of 64 cases of ALD and in 4.2% of 72 cases of non-alcoholic liver diseases. (Fig. 4,5)

We have found this reasonably consistent finding in alcoholic liver disease to be an exceptionally useful adjunct in the confirmation of ALD and recommend its routine and wider use.

We are presently continuing this study of IgA[20] in the liver in order to confirm the validity of these findings, to attempt to understand this phenomenon and any possible role IgA deposition may have in the inception, perpetuation or susceptibility to alcoholic injury.

Summary and Conclusions

The confirmation of alcoholic liver disease, while critical, is difficult. The clinical signs and symptoms, the clinical laboratory data and the liver biopsy findings are all generally nonspecific. A history of chronic alcoholism may be less than reliable. A reliable history may still not confirm the diagnosis. No more than a third of chronic alcoholics develop progressive alcoholic liver disease and chronic alcoholics can and do develop nonalcohol related diseases of the liver.

The liver biopsy remains the most definitive means to confirm diagnosis of alcoholic liver disease. Our goal was and is to increase the usefulness of the liver biopsy. We assessed three morphologic markers for their specificity in the confirmation of ALD pericentral and lobular sclerosis, giant mitochondria by light microscopy and IgA deposition in the liver.

Our tentative conclusions, based on a review of the literature and our own work, suggest that pericentral and intralobular sclerosis, while characteristic for ALD, is a non-specific change that also occurs in non-alcoholic liver disease. Our studies reveal that giant mitochondria by light microscopy are characteristic for ALD and are a useful adjunct in confirming the diagnosis. Giant mitochondria may be difficult to identify in tissue sections and have been found in no more than half the cases under the best of circumstances. The deposition of IgA in a characteristic continuous pattern of deposition in the liver is a reasonably consistent finding suggestive of the diagnosis of ALD. The deposition of IgA in the liver merits further study, validation, and explanation.

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Leadership

By Susanne Webb, ISMSA President

There are five steps to being an effective leader: (1) planning, (2) organizing, (3) staffing, (4) directing and (5) controlling.

Planning is the essential ingredient. Long range planning establishes goals for the organization. These goals should be measurable and verifiable, attainable and realistic, set within a time frame, ranked in priority and limited in number. Short range plans are the means to achieve long range goals.

Decision making is an integral part of planning. There are five steps to decision making: (1) Define the goal (or problem)—don't confuse symptoms with causes; (2) Generate all possible alternatives—try brainstorming with no criticism, free wheeling ideas, improving and combining; (3) Analyze and evaluate—keep steps 2 and 3 separate, don't cut step 2 short; (4) Select the best alternative—this may involve bargaining as members of a coalition and (5) Implement—a decision does no good unless acted upon.

A crisis is not a good time to make decisions; try to avoid reaching crisis situations. People in groups tend to make riskier decisions. Eighty-five per cent of the time the most vocal idea is accepted. Group decisions have a higher level of acceptance and, hence, may be easier to implement, but are more time consuming to reach.

Organizing is deciding how the job will be done. Coordination is important to avoid duplication of effort. Each meeting should have an agenda.

Staffing is selecting the people best equipped to do the job with technical skills which are job specific, transferable or functional skills, and personal skills unique to the individual.

Directing is getting people to actually do the job. Communication is an important factor. A leader should be clear and concise. Motivation is another variable in directing. The reinforcement theory recommends rewards for desired behavior. Rewards may be intrinsic (a good feeling of contribution) or extrinsic (pay or promotion). In a volunteer organization recognition is the most valuable reward for efforts expended. Competition between individuals and/or groups can be a motivator.

Controlling is evaluation. Goals are pointless unless they are achieved or attempted. If goals are not being accomplished, they may need to be changed. Certainly, long range plans should be reviewed regularly.

Following are a few observations on organizations (groups). The two primary functions of groups are task achievement and a social-emotional function. Auxilians are definitely people for whom work is natural, who seek responsibility, are self directing and will delegate authority and decision making.

In conclusion, there are two theories about leadership. The normative theory is ideally what should happen and the descriptive theory is what actually does happen. In practice we fall somewhere in between the two. We can all be better leaders by applying the principles of planning, organizing, staffing, directing and controlling. ◀

A Systematic Approach To Prison Health Care

By Jerry L. Beguelin, M.D./Irvington

The problems facing administration of effective health care in prisons are uniquely complex, and the solutions to these problems cannot be achieved by traditional standard medical procedures alone. In order to most safely and most economically provide adequate and accessible medical care in correctional institutions, an integrated and systematic approach to prison health care best responds to the needs of this underserved population. At Pontiac Correctional Center the prison health project of the Irvington Mental Health Center initiated such a system by revising the organization of personnel, the security arrangements and the procedures for medical care.

In 1972, U.S. District Court Judge Frank M. Johnson unleashed a wave of activity in prison health care when he ruled in *Newman v. Alabama* against the State of Alabama correctional system on the basis that "the intentional refusal by correctional officers to allow inmates access to medical personnel and to provide prescribed medicines and other treatment is cruel and unusual punishment in violation of the Constitution."

Gradually, state after state was faced with similar lawsuits (including the State of Illinois in *Lightfoot v. Walker),* and it became apparent that inmates must be given proper medical attention in prison, or released from confinement. Faced with such a possibility, prison officials and health authorities began to delve more deeply into the problems with medical care in correctional institutions.



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Problems in Prison Health Care

The plight of inadequate medical care in prisons results not merely from the public's ignorance of, or insensitivity to, human suffering, nor the taxpayer's unwillingness to provide funds to "coddle" lawbreakers. These can be seen only as partial explanations. There are inherent in prison health care unique problems resulting from necessary security precautions and from the restrictions placed on the inmates. While on the one hand, the medical staff is hampered in its diagnosis and treatment by its dealings with sometimes uncooperative, deceptive, and poten-

tially violent patients, the inmates, on the other hand, sometimes cannot obtain treatment for serious, legitimate complaints.

As the 1972 Alabama court case made clear, a primary problem in prison medical attention is access to care. Since the movements of prisoners are strictly curtailed, an ailing inmate traditionally needed to win the sympathy and confidence of a security officer, usually one who had no training in medical triage, in order to gain access to medical care. In effect, the security guard was making diagnoses and referrals, for if he did not consider the inmate's complaint worthy of attention, none was given. When medication or treatment was prescribed by a physician, the implementation of his orders was often assigned to the security force which was required to distribute medicine and follow-up on the condition of inmates. Such a procedure could also subject the security officer to inmate complaints that medication or access to medical care was being denied to him as a disciplinary weapon.

Even if the inmate could clear preliminary screening by the guard, he still might be unable to obtain proper medical attention due to insufficient medical personnel, unavailability of medical providers at certain hours of the day or week, or lack of facilities and equipment. Sometimes inmates with serious or chronic ailments were denied access to specialty care. At its worst, the prison medical record yields horror stories of inmates operating on one another, prison hospitals with algae growing on the floor, and convict "doctors" selling medical leaves of absence.[1]

Once again, though, because of the unique situations in prison life, in most cases the problem with medical care is more complex than simple insensitivity or mere economic neglect. First of all, in a prison environment there is an increased utilization of sick call services.[2] This is due partly to the institutional character of the prison, which leads to greater incidence of disease; partly to the nature of this particular institution where aggressive and violent acts occur more frequently than in the general population and partly to the sociological fact that the majority of those imprisoned come from lower socio-economic groups whose access to medical care prior to imprisonment often was limited.

However, an even greater burden is placed on the medical staff of a prison, because sick call is often sought not for medical reasons but for sociological, psychological, personal and even criminal purposes.[3] In prison, particularly in a prison with few vocational opportunities, sick call can be a recreational or social event which breaks up the monotony of the day; or, conversely, a means to avoid work or other unpleasant assignments. An inmate may request to go on sick call in order to receive or steal medication, which can be used for nonmedical reasons or sold to other inmates, or in order to use the medical facility as a contact point to meet other inmates and exchange contraband. A prisoner might seek hospitalization in order to obtain more pleasant living conditions, to seek asylum from other prisoners, or as part of an escape plot.[4] The health care provider may spend much time listening to fabricated or exaggerated complaints, and as a result patients with legitimate medical problems may not be given adequate attention.

Particularly time-consuming are increased requests in prisons for psychotropic drugs for nonmedical use. Some institutions sanction the mass utilization of drugs for the tranquilization and control of inmates, but in those institutions where authorities believe such a tactic to be improper, inmates are continually feigning physical or mental illness in order to obtain mind-altering drugs which are used as a means of "escape" from the confinement and monotony of prison life or as a valuable commodity to be used in exchange for other prison luxuries.

Staffing Problems

While there is a proportionately greater demand on the medical facilities and staff of correctional institutions than in the general population, there are fewer medical personnel who wish to become involved in prison work.[5] Particularly with the sometimes limited amount of funds budgeted for health care providers, it can be difficult to recruit the medical staff necessary for adequate medical care. This is especially true of physicians for whom prison work is not as prestigious as private practice and in many cases not as economically profitable or personally rewarding. However, an increase in salaries is not a panacea; even when salaries are competitive, there is still difficulty in attracting a well-trained medical staff. Some health care providers become frustrated with overlapping services or unclear responsibilities, with the necessary security precautions which delay patients and supplies, and with the extra paperwork and legal actions that prison work often entails. For others, the environment within a prison constitutes unpleasant and even depressing working conditions. Fear for personal safety, fear of sexual assault and harrassment, and fear of aggressive and belligerent patients discourages still others.

Hence, security considerations form another obstacle to proper medical care in prisons. Un-

TABLE 1

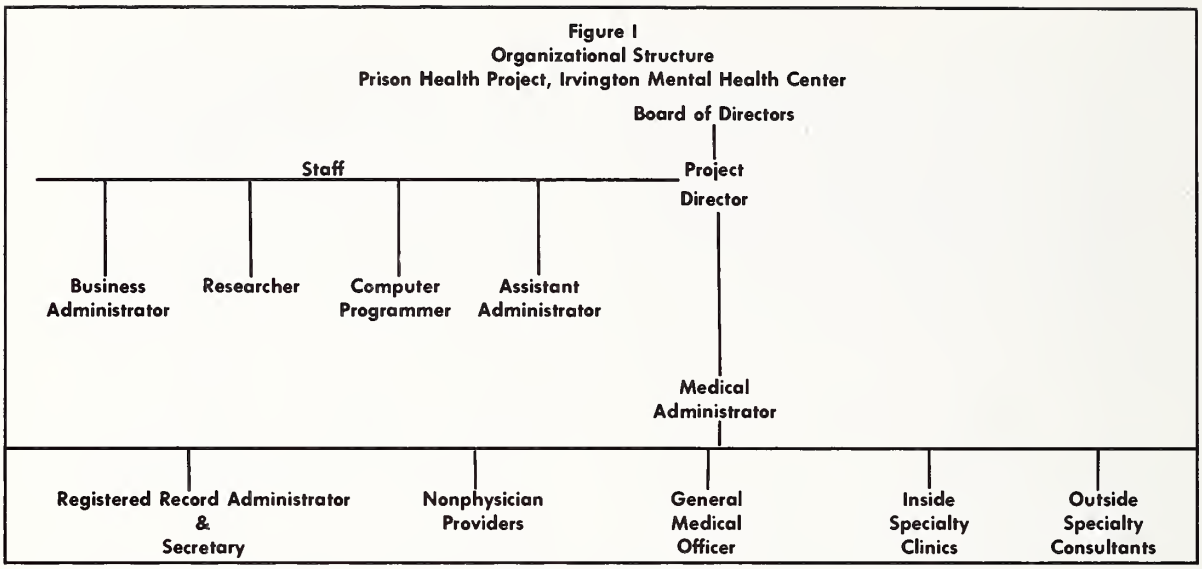
1. In order to ensure access to proper medical care, each inmate should have one primary health provider who will serve as the portal of entry into the health care system. This provider should be able to care for 80-90% of the presenting complaints; he should be able to triage the remaining 10-20% to the appropriate level of specialty care. Since the provider is assigned a defined patient population, (based upon the terminal digit of the inmate's number) he should develop some familiarity with the patient's medical history. This should give more continuity to the care administered and perhaps encourage a more agreeable provider-patient relationship.
2. In order to meet the demand for health care providers in the most cost-effective manner, nonphysician providers should be utilized to administer routine health care, as recommended by the U.S. Department of Justice's Law Enforcement Assistance Administration.[7] Nonphysician providers have already proven their effectiveness within and outside prison walls, and it has been estimated that nurse practitioners and physician assistants together can meet the medical needs in 90% of the cases of prisoner complaints.[8]
3. In order to ensure the inmate's access to proper medical attention a procedure should be established whereby requests for health care can by-pass security and can be made directly to someone of the medical staff. Also, every inmate making such a request should be seen by some member of the health team within twenty-four hours after filing his request.
4. In order to facilitate the inmate's access to specialty care and in order to minimize security risks of transportation, specialty consultations should be available in the prison. Since usually the same specialist will be available to the patient, this also should result in better continuity of care for the inmate.
5. In order to ensure a continuity of care, a unit medical record should be established for each patient.
6. In order to protect the lives and safety of the medical personnel and in order to provide an atmosphere conducive to medical treatment, sick call must be held in a tightly secured area. If necessary, sections of older prisons should be redesigned to meet this requirement.
7. In order to forestall serious problems and maintain consistent and adequate medical care, medical care evaluation studies should be conducted on an ongoing basis to assess the quality of medical care provided.
8. In order to keep abreast of new findings and of the literature in the field, a support staff should be available to research and evaluate trends and procedures and provide suggestions for the improvement of health care in prisons.

fortunately (but inevitably) ideal medical practice and maximum security precautions can make contrary demands on prison authorities; concerns for both the safety of medical personnel and for proper supervision and containment of prisoners complicate the practice of medicine behind the walls of prison. The transference of inmates to and from the medical facility, the supervision of the waiting-room, the design of the clinic—all of these become literally vital concerns for those treating inmate patients.

Necessary security precautions affect the inmate-patient particularly when he is in need of specialty care or operative procedures. Generally patients recommended for specialty consultations need to be transported to community hospitals or medical centers, since few are available within the prison itself. Consent to transport a prisoner beyond the prison gate is understandably not readily granted by prison authorities; once again an inmate's access to proper medical care may be restricted to some degree.

Another problem common in prisons which militates against effective health care is the frequent lack of adequate medical records. Often there is no unit record; rarely is there a problem list.[6] To further complicate the problem, inmates admitted to prison sometimes assume various aliases or list different dates of birth. In a correctional system with a constant influx and discharge of prisoners and transfers from one institution to another, a patient's medical history could be temporarily lost, or it could prove difficult to have it forwarded from an institution where the prisoner had previously served time. Particularly when a patient with a chronic complaint was seen by a number of different medical providers over a period of years, it was possible for one physician to be unaware of prior treatment or diagnoses. As a result, a patient might not be given the benefit of a consistent and comprehensive treatment plan, and in extreme cases, might even be placed on treatment plans which are incompatible with one another.

One final problem is the traditional lack of professional interest in prisons and prison health care. In the medical field this trend has begun to be reversed since the early 1970 court decisions ruling that inadequate health care in prisons constitutes "cruel and unusual punishment." Published research on the problems and solutions in the prison health field is continually increasing, and professional groups are beginning to take an active interest in the care and treatment of prisoners. This is as evidenced by the conferences on medical care and health services in correctional



institutions, sponsored by the American Medical Association. However, if the problems cited above are to be solved, there must be still more detailed research into the actual state of medical care in prisons, into the complex causes for the traditionally inferior level of care given, and into possible remedies for the conditions which, in some cases, have been judged to be cruel and unusual.

Guidelines For Improvement

Since October of 1977, our center has had responsibility for the medical care of the prisoners at Pontiac Correctional Center, a state maximum security prison housing 2000 inmates. The prison health project has as its goal the development of a systematic approach to prison health care, and to accomplish this it has formulated a set of principles which serves as a basis or philosophy for a comprehensive and integrated plan for medical care. (See Table 1).

Implementation Of Guidelines

Using these principles or guidelines as a basis, we developed an organizational structure of personnel, plans for tighter security for medical care, and a set of procedures to administer medical care—all of which were designed to clarify, systematize, and safeguard the operations involved in prison health care. It was hoped that these proposals and revisions could help to minimize some of the problems traditionally associated with health care in correctional institutions.

First of all it was thought essential to design an organizational structure which would establish channels of authority and clearly delegate responsibility for each aspect of medical care. As the resulting organizational chart demonstrates (see Figure 1), the project director is assisted in the maintenance and development of the health care project at Pontiac Correctional Center by a staff consisting of (1) the *business administrator* who controls and coordinates the business and business records; (2) the *literature researcher* who investigates the published materials pertaining to the improvement of prison health care; (3) the *assistant administrator,* who evaluates administrative procedures from a health systems approach in order to determine cost effectiveness of various systems and to assist in the evaluation of written procedures and (4) the *director of computer management* who is responsible for the development of a computer based management program which involves minimally a patient master list filed by inmate number, a problem list, and a current drug list. Second in authority to the project director is the *medical administrator* who is responsible for the day-to-day operations of the health care system at Pontiac. The medical administrator also serves as the liaison to the correctional center's administrative officers and personnel, and in most cases he is the one who handles problems and grievances.

The medical care itself is administered by the nonphysician providers, the general medical officer, inside specialty consultants, and outside consultants on the following basis: (1) routine

care is available from one of the nonphysician providers eight hours a day, five days a week; (2) the general medical officer is available 40 hours a week inside the prison; (3) inside specialty consultants are scheduled for various specialty clinics from once every two weeks to once every two months depending on the specialty; (4) in-prison emergency care is available from a nonphysician provider eight hours a day, seven days a week and (5) outside consultants are available at need to provide care in community hospitals or tertiary care centers for procedures that cannot be performed within the prison.

The *nonphysician providers* are either licensed physician assistants or registered nurses with additional training in ambulatory care. These nonphysician providers are under the direct supervision of a licensed physician and utilize protocols for the delivery of routine medical care. The nonphysician provider is the first line of contact between inmate and the medical system. He or she refers to the established protocols to determine what treatment the patient requires. The protocol may specify that a particular diagnostic procedure should be done, such as an X-ray or laboratory tests; or the protocol may call for a specific drug therapy to be instituted; or it may direct the nonphysician provider to refer the patient to the physician on sick call (either on a routine or emergency basis) or to refer him to a specialty clinic. All encounters with inmates are documented in a problem oriented format. Because of this direct supervision and utilization of protocols, the performance of the nonphysician providers can be audited.

The *general medical officer* is available 40 hours a week as a consultant to the nonphysician providers and to the prison nursing staff. He treats the patients referred to him by the nonphysician providers and is in charge of the medical care of inmates in the infirmary.

Specialty clinics are held for 1) general surgery—every two weeks; 2) orthopedic surgery—twice a month; 3) ENT—every two months; 4) diabetic and hypertensive—every two weeks; 5) cardiology—every two months; 6) dermatology—twice a month; 7) neurology—once a month; 8) urology—once a month. These specialty clinics increase the accessibility of specialty care for inmates and provide for continuity of care.

Essential for the evaluation of medical care over a period of time is the *registered record administrator,* who, with the assistance of the *medical records secretary,* maintains files on all professional staff, develops and maintains lists of patients with chronic illnesses, provides a monthly calendar of specialty clinics and maintains lists of patients referred, maintains statistics on patients seen, and develops and implements procedures whereby inmates having special diagnostic tests will be informed of the results which will then be entered in the patient's record. The medical records staff has already established for each inmate a unit problem-oriented medical record which was developed by Dr. Leslie Sandlow, vice-president of medical affairs at Michael Reese Hospital in Chicago. Since September of 1978, training sessions have been conducted and materials prepared, and now the maintenance of the unit records for each inmate is fully operational. In May of 1979, medical care evaluation studies are scheduled to begin in order to determine the effectiveness of the current medical policies and procedures.

Security precautions for a health care unit in a maximum security prison involve two considerations: regulation and control of the prison population and the protection of the health care team. Prisoner movement to and from a medical appointment creates more possibilities for escape or riot, and the meeting of inmates at the health care center facilitates the passing of illegal or dangerous contraband. For instance, when the nonphysician providers first began treating inmates, a sick call room was established in each cell house, and all inmates requesting to go on sick call were released at the same time, with the result that as many as 50-100 prisoners could congregate in and about the sick call room under the supervision of perhaps only one guard stationed at the other end of the gallery 50-100 yards away. It is obvious that under such conditions a prison guard would be reluctant to permit the movement of prisoners for health care reasons.

Response to Crises

In July, 1978, rioting occurred at Pontiac Correctional Center and three correctional officers were killed. The impact on health care services was that all prisoners were placed on "deadlock," (inmates were confined to their cells) and medical personnel were required to walk the galleries in each cell house on a daily basis. This resulted in wasted time for the nonphysician providers and in unnecessary contacts with inmates who halted the providers solely to escape boredom.

Following the riots, the medical unit refused to work under those security arrangements and changes were proposed. To decrease the movements of inmates to the infirmary and pharmacy area, sick call was moved out of the hospital facility (where it had been conducted at the time

of the riot) and into a specially designated area which was made secure through sufficient security personnel and architectural redesign. The area houses a waiting room, a place for specialty clinics, individual offices for the nonphysician providers, and an office for the registered records administrator, medical unit administrator, and the medical records secretary. The new plan allowed for tighter supervision of the inmates and minimized risk to the health care team.

Finally, new procedures have been proposed for the inmate to request and to receive health care. Inmates who wish to be seen on sick call place their name, inmate number, and cell house on a slip of paper and deposit it in a box at breakfast. The identification number is important, for its terminal digit determines to which provider room and to which physician-assistant he will be sent; the cell house in which he resides determines at what time of day he will be seen. Under the supervision of the medical secretary these slips are collected and inmates are assigned to appointments for that same day. Inmates who believe they need emergency attention ask security to call the medical unit, these calls are responded to by the nonphysician provider assigned to emergency care, and he then instructs security on the disposition of the case.

These newly formulated procedures and the redesigned facilities should guarantee inmates proper access to adequate medical care, and at the same time should reduce security risks.

Conclusion

This article has considered an increasingly popular method to provide medical service in a prison setting. There are alternative arrangements also in use, and the model described is not the only feasible approach. It is the concept of contractual medical services that is new. Its viability is supported by the fact that the State of Massachusetts has contracted with a private psychiatric hospital to provide all the psychiatric services for one of their security institutions.

Of course, not all penitential facilities experience the health programming difficulties described in this paper. Still, this service contract arrangement for prisons may provide a potential solution to the traditionally problematic issue of poor prison medical care. ◀

References

A complete list of references for "A Systematic Approach to Prison Health Care," by J. L. Beguelin, M.D., may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

Illinois Jail Health Program

From 1978-1981, the Illinois State Medical Society administered the Illinois Jail Health Program (IJHP). The IJHP was one of a number of state medical society-sponsored programs funded under a subcontract with the American Medical Association to provide technical assistance to county and state correctional facilities and agencies in the development and improvement of health care services to inmates. The AMA had received a grant for this from the federal Law Enforcement Assistance Administration (LEAA). Under the program, the AMA was to (1) create standards for health care in jails; (2) develop an accreditation program to recognize facilities meeting the standards and (3) provide technical assistance to jail officials.

During its peak period, the IJHP provided assistance to one-third of Illinois jails. This assistance ranged from answering phone and mail requests for materials to visiting county jails in order to identify and suggest remedies for their problems. In addition, training programs were held around the state to prepare correctional officers to handle routine and emergency medical situations and to function under an organized and uniform system of health care delivery.

The IJHP ultimately assisted four county jails (Cook, Kane, McHenry and Champaign) to meet the requirements for accreditation. ISMS staff continues to assist the AMA in surveying facilities applying for this form of recognition.

The article which follows describes the largest county jail in our state, and one of the largest in the country. The problems of Cook County are essentially the same as those of most jails, except magnified several times over. The important aspect to recognize is that a county jail must serve as a component of the public health services in a community. To ignore that facility and its residents is to deny the existence of a segment of the population. This segment will soon return to the community and its members. Good health and medical care in jails can contribute to a healthy community. ◀

Case Reports: Health Care At Cook County Department of Corrections

By John M. Raba, M.D., Chicago

Cermak Health Services delivers health care to detainees at the Cook County Department of Corrections on Chicago's near Southwest Side. The facility houses 5,000 men and women on a 54 acre site, admitting nearly 150 individuals on any given day. On an annual basis over 55,000 men and women enter the doors of "Cook County Jail". The average length of stay is 21 days. Most of these individuals are soon to be back in the neighborhoods of Cook County.

The sheer size and numbers of this institution demand an extensive medical staff in order to screen all new admissions for psychiatric and medical disorders, provide 24 hour emergency medical services, and maintain frequent sick calls to handle chronic and routine medical problems. At present, Cermak Health Services has a staff of 234 persons including 15 physicians, (10 full time equivalents) 7 physician assistants, 33 nurses, 67 emergency medical technicians, 8 dentists, and 52 members of the psychiatric team. On site specialty clinics in orthopedics, urology, general surgery, ear, nose & throat (ENT), dermatology, ophthalmology, and diabetes mellitus are held weekly. A physician is on site 24 hours a day. Detainees requiring hospitalization are sent to Cook County Hospital where all Cermak's physicians have staff privileges.

Urban jails are in the enigmatic position of rapidly becoming significant health care providers, albeit on an intermittent basis, for a large and growing subsector of city populations.

With rapid turnover of sizable numbers of low income, young, mostly minority men and women, whose communities of origin are without health care providers, urban jails can screen, diagnose, treat and counsel their admissions for contagious and chronic disease—problems which, if left undetected, would result in higher morbidities and increased need for costly care at a later time. A jail health program can be instrumental in improving the health of the detained individual as well as the community at large.

Cermak Health Services staff continues to be amazed at the high incidence of illness in this young (24 year old) population. A total of 20% have borderline or definite high blood pressure, 5% have gonorrhea (many asymptomatic) 3% have latent syphilis, 22% have positive PPDs, 0.1% have active tuberculosis (10 × the USA rate). A total of 21% have had a long bone fracture, a gunshot wound or a stab wound within the past five years. Even at these relatively older ages, 0.4% of the men have uncorrected undescended testicles. The incidences of drug abuse, hepatitis, epilepsy, and psychiatric disorders are strikingly elevated.

The care initiated and continued at the Cook County Department of Corrections has and will have major public health implications not only in the jail but also in the Chicago municipal area. Detecting and treating contagious disease at the time of entry in the jail is paramount in preventing epidemics in the "barracks-like" setting of this correctional facility. Persons with chronic illnesses must have their ongoing medications continued to avert potentially catastrophic deterioration during incarceration.

The Chicago Department of Health estimates that 15,000 cases of gonorrhea and nearly 100 cases of tuberculosis are prevented annually in the City of Chicago by the screening done by Cermak Health Services. The long term gain from the early diagnosis of hypertension is also not to be overlooked. The stabilization of detainees with psychiatric disorders while they are in the Cook County Department of Corrections has a positive impact on those communities to which the detainee is soon to return.

Quality medical care in jails not only is legally and constitutionally indicated, but may be among the most productive public health, preventive medical programs in some communities in Illinois. Sick detainees in jails will soon be sick citizens on the street. The benefits of adequate care by Cermak Health Services reach out beyond the walls of the Cook County Jail. This can also be true of any city or town in Illinois. ◀

John M. Raba, M.D., is medical director of Cermak Health Services in Chicago. A board certified internist, Dr. Raba is also an attending physician in the departments of internal medicine and family practice at Cook County Hospital.

The Viewbox

CONTRIBUTING EDITOR TERRENCE DEMOS, M.D., ASSOCIATE PROFESSOR OF RADIOLOGY,
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This month's Viewbox was contributed by Kathleen A. Gadwood, M.D., assistant professor of radiology and Terrence C. Demos, M.D., associate professor of radiology, department of radiology, Loyola University Stritch School of Medicine.

A full term, healthy, newborn baby was found to have a palpable abdominal mass.

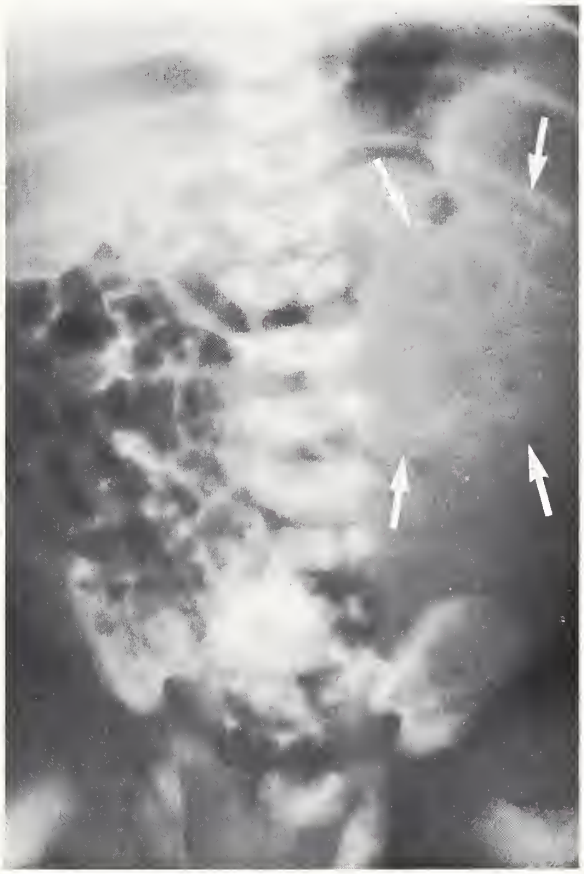


Figure 1
Excretory urogram. Bowel gas is displaced to the right side of the abdomen. There are multiple curvilinear densities on the left (between arrows). The right kidney, obscured by bowel gas, is normal.



Figure 2
Ultrasonogram. A longitudinal image through the left side of the abdomen shows that the kidney has been replaced by numerous cysts (asterisks).

Your diagnosis?

(1) Infantile polycystic kidney
(2) Fetal renal hamartoma
(3) Renal vein thrombosis
(4) Multicystic dysplastic kidney
(5) Wilms' tumor

(Continued on page 438)

General Assembly Considers 800 Medically Related Bills

During the 1983 General Assembly session, state lawmakers considered a wide range of legislative proposals affecting the medical profession—from the abolishment of state-required continuing medical education to far-reaching hospital cost control measures.

The sometimes hectic session saw nearly 3,700 bills considered by state representatives and senators, including more than 800 relating to medical care. ISMS lobbyists, armed with positions developed by the Society's House of Delegates, Board of Trustees and Council on Governmental Affairs, in conjunction with state specialty societies, worked to support favorable legislation and oppose that contrary to the interests of physicians and their patients. So intense was physician interest in legislative matters that when a proposal to assess interest on malpractice damage awards prior to judgment of a claim surfaced, more than 1,000 communications from ISMS members were dispatched to Springfield.

"ISMS' effective grassroots response to the challenges posed by the recent legislative session was further evidence of why the Society has been characterized by Illinois news media as one of the most powerful and politically astute groups working in the state capitol," said Dr. Warren D. Tuttle, chairman of the ISMS Board of Trustees. "We're certainly proud of our continued achievements on behalf of Illinois physicians."

However, Dr. Tuttle cautioned the ISMS membership not to be complacent about recent legislative success. "Many of the battles fought in the legislative chambers will recur in future sessions," he said. "When they do, we must be ready to again devote our best resources to confronting them."

Following is a review of some of the major medical issues the legislature considered last session. A more complete listing of bills—and the ISMS position on those matters—appears on page 426. Physicians might also note two special articles contained in this legislative issue. One concerns the Illinois State Medical Society Political Action Committee, the separate "campaign arm" of the state medical society and an integral tool in its government relations program *(page 425)*. The other concerns the Society's "Key Contact" program, a vital concept of grassroots participation in medical lobbying efforts *(page 424)*.

Continuing Medical Education

Near the close of General Assembly business, legislators voted overwhelmingly to end required continuing medical education for physician relicensure. Some called the measure "the surprise of the legislative session," for the proposal had moved through the legislative process smoothly, attracting little attention.

The House vote was 78 yes, 23 no and 10 present. The inclusion of the CME amendment was sponsored by Rep. Michael Tate (R-Decatur) and Rep. Harry "Babe" Woodyard (R-Chrisman). In the Senate, ISMS lobbied with the bill's sponsors—Sen. Prescott Bloom (R-Peoria) and Sen. Max Coffey (R-Charleston)—to gain the Senate's 58-to-0 approval.

Since 1978, the state required all physicians to prove that they had successfully completed 100 hours of mandatory CME every two years. Proponents of the bill repealing required CME argued that their bill did not signal an end to continuing medical education; indeed, they maintained, physicians have always considered continuing education to be a fundamental responsibility of the licensed practitioner.

Even with passage of the bill into law, many physicians still will be required to participate in CME for hospital medical staff membership credentialing, and board certification and re-certification. Satisfying CME requirements also will continue to be mandatory for some specialty society memberships.

The vote in Illinois for voluntary CME was considered to be a reflection of the national trend away from mandatory CME. Across the nation, 25 states have laws requiring CME, but only 19 states actually enforce those laws. In Colorado, a state which recently rescinded the mandatory CME provision, members of the state medical society have reported no substantial reduction in the number of physicians attending CME programs.

Interestingly, ISMS accreditation of CME programs had existed for 10 years before the 1978 law was enacted. The medical profession was concerned

ISMS Key Contact Program Opens Doors To Physicians

One of the more successful aspects of the legislative activity performed by the Illinois State Medical Society has been the Key Contact Program—a system in which physicians develop relationships with their legislators and serve as influential contacts on particular issues that rise before the legislature.

"Lobbying efforts are far more effective when a legislator has a friend or acquaintance talking to him about the issue. It's only natural for the legislator to trust what a friend has to say and be persuaded by his opinion," said Dr. Herbert Sohn, chairman of the ISMS Public Affairs Committee.

Medical issues are complex, often requiring the "insider's view" of a physician. Legislators welcome a physician's expert opinion. Moreover, as community leaders, physicians provide legislators with important insight into the issues of concern to a legislator's constituents.

"The program operates very simply," Dr. Sohn pointed out. When an issue comes before the General Assembly or Congress, ISMS provides the Key Contact physician or spouse with background information and a detailed explanation of the medical society's position on the matter. Then, after reviewing the information and familiarizing himself with the ISMS stand, the physician or spouse contacts the legislator and solicits support for the ISMS position.

Relationships with legislators can be developed on a personal basis or with the assistance of the ISMS staff. Key Contacts are asked to participate on only major issues and, even then, the physician or spouse is asked only to write or telephone the legislator. Personal meetings with legislators can also enhance effective communication. There are no group meetings or other time-consuming activities to keep physicians away from their practices.

To join the ISMS Key Contact Program, call the ISMS Governmental Affairs Division at 312-782-1654. ◀

about quality CME long before the state pursued mandatory professional learning.

Pre-Judgment Interest

Many legislators have remarked that they had not witnessed grassroots physician involvement like that which occurred on pre-judgment interest on any issue since 1975—in the midst of the dark days of the malpractice crisis, when sources of professional liability protection threatened to disappear.

Senate Bill 87 called for the assessment of interest on judgments starting shortly after the occurrence of the incident which gave rise to the suit. ISMS calculated that a 10 percent interest rate compounded annually would double the award during the several years it often takes to litigate a claim.

ISMS governmental affairs personnel worked diligently in both chambers and lobbied strongly against passage. Dr. Fred Z. White, chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange, wrote policyholders, urging them to contact their legislators. And the physicians responded.

A deluge of more than 1,050 copies of correspondence sent to the state's 177 legislators was received at ISMS headquarters. General Assembly members reported receiving countless other communications—including mailgrams, telephone calls and personal visits.

Attempts to pass the bill in the Senate were rebuffed, as the proposal received only 14 positive votes with 41 nays. In the House, a similar bill faced similar consequences. Apparently recognizing the doomed destiny of his bill, the House sponsor—Rep. Daniel Pierce (D-Highland Park)—refrained from calling the bill for a vote. That bill was placed on the Interim Study Calendar, where it remains alive for possible consideration next year.

Added to the fiery debate on pre-judgment interest were direct, unsubstantiated attacks on the Illinois State Medical Inter-Insurance Exchange by trial attorneys anxious to have the bill approved.

Medical Studies Act

In May, two measures that would have rescinded provisions of the Medical Studies Act and undermined the confidentiality of peer review records were successfully opposed. One bill, H.B. 1548, sought to allow patients and their attorneys access to peer review records to determine if the patient's care met acceptable standards and would have permitted admission of those records as evidence in court.

The bill was scheduled for a hearing before the House Judiciary Committee, a panel dominated by lawyers and chaired by the bill's sponsor. ISMS lobbied the committee heavily and managed to persuade the bill's sponsor that the necessary votes for approval were not obtainable. A hearing on the bill was postponed and it was placed on the Interim Study Calendar.

The Campaign Trail

IMPAC Supports Those Who Support Medicine

In addition to voting for a particular candidate at election time, a person also may volunteer time or donate money for a candidate's campaign if he or she agrees with the candidate on the issues. Supporting someone who supports you is a fundamental and accepted rule of politics.

The Illinois State Medical Society Political Action Committee acts no differently than the individual voter. IMPAC supports candidates—in a non-partisan fashion—who are friends of medicine. However, IMPAC differs from the individual voter in one important way: numbers.

"There's strength in numbers," maintains Dr. Cyril C. Wiggishoff, IMPAC chairman. "While important, my personal contribution to a candidate won't win an election. But the contributions of several physicians together—through IMPAC—can help turn an election around."

Examine the IMPAC record:

- In the November 1982 elections, IMPAC supported 184 candidates. Of those, 153 were elected: an 85 percent success rate.
- During that election, IMPAC supported a Republican candidate who was a strong supporter of organized medicine in a Chicago state representative race—a rather bold undertaking in a Democratic stronghold. IMPAC support included the production and distribution of campaign literature, monetary contributions and general organizational assistance. The candidate is now the one—and only—Republican out of 38 representatives from Chicago.
- IMPAC helped elect candidates who advocated physician-supported malpractice reforms, medical disciplinary revisions and measures designed to improve third party payer reimbursement procedures and rates.
- IMPAC helped elect candidates who opposed expensive health planning, the practice of medicine by those who are unqualified, and windfall profits gained through pre-judgment interest legislation.

Many believe that fights over legislation are won or lost on election day—that *who* is elected to office will determine *what* legislation is proposed and passed. IMPAC offers one avenue to help secure the support of medicine's allies on a legislative issue long before the floor votes are ever tallied.

IMPAC gives physicians the opportunity to enhance their individual participation in the governmental process. IMPAC supports those who support medicine. Physician support of IMPAC is necessary for its continued success.

ISMS members can join IMPAC* by sending a $45 check payable to IMPAC ($65 if an AMPAC membership also is desired) to 55 E. Monroe, Suite 3510, Chicago, IL 60603. Sustaining memberships and pins are also available for a $99 contribution. ◀

*Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations. Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

In the upper chamber, a similar bill was also headed for a committee hearing. ISMS presented its position to the bill's sponsor, and the bill ultimately was tabled in commmittee.

In related judicial action, a recent trial court ruling holding the Medical Studies Act unconstitutional has been appealed, and the Illinois Supreme Court has allowed ISMS to enter an *amicus curiae* (friend of the court) brief.

Living Will

Opposed, debated, amended and ultimately approved, the so-called "living will" legislation was the object of much interest not only on the floor of the state legislature, but also by the state's news media.

The legislation allows a person to draft written instructions for a physician to withold life-sustaining measures. ISMS opposed the controversial legislation on the basis that the bill exposed Illinois physicians to greater liability, and that a "living will" might not accurately reflect a patient's informed consent. As debate on the bill progressed, ISMS recognized the widespread popular and political support the bill had garnered and chose to suggest particular amendments for the legislation.

The amendments, which were adopted for the final bill package, include: (1) the provision that only the attending physician (rather than two physicians) certify the terminal condition; (2) the extension of immunity from civil or criminal liability to physicians who certify a terminal condition; (3) the specification that no physician shall be required to act in violation of his personal beliefs, morals or conscience; and (4) the elimination of a section advocating penalties for physicians who do not follow the terms of the living will (common law penalties could still be applied).

Optometric Drugs

One of the toughest medical battles in Springfield illustrated how effective ISMS lobbying can be for a specialty society with a specific concern.

The 1983 session was marked by a number of defeated attempts to pass legislation that would allow some optometrists to administer topical drugs.

A last-minute effort to approve optometric drug language was thwarted by intensive legislative activity conducted by ISMS working with the Illinois Association of Ophthalmology. Illinois remains one of only 10 states in the nation that has managed to withstand the organized efforts of optometrists to pass such legislation.

Hospital Revenue Act

From the beginning of the session, a dispute had been brewing over S.B. 495—the proposed Hospital Revenue Act. Business groups, insurers and labor unions were determined to obtain passage of the act. Objecting to the potential consequences the measure posed for quality medical care and the economic viability of hospitals, ISMS joined the Illinois Hospital Association in opposition.

Before coming to a crucial, deciding vote, negotiators on both sides of the issue compromised, agreeing that the Act deserved further study and discussion. Instead of calling for a vote, the Senate adopted a resolution calling for the establishment of a select committee to examine the issue more thoroughly.

The Senate Select Committee on Hospital Cost Containment is comprised of five senators and an advisory panel of 22 members representing hospitals, physicians, business, labor, insurance companies and senior citizens. The committee is charged with making a report to the Senate no later than March 1, 1984. The report is to include "an analysis of the problem of excessive hospital and insurance costs; an analysis of the underlying causes of health care cost increases; and recommendations on amendments to S.B. 495, if any, to address the problem of excessive hospital and health insurance costs."

Veto Session

Immediately upon the close of the session, ISMS officers and staff remained hard at work analyzing final proposals passed by the legislature and the action of Governor James R. Thompson. Society representatives returned to Springfield to ensure physician input in the legislature's reconsideration during the fall veto session of any bills vetoed outright or amendatorily by the Governor.

Specific Bills Detailed

The list below includes a small proportion of the more than 800 bills related to medicine which were considered in this legislative session. More detailed information may be obtained by contacting the ISMS Governmental Affairs Division. ◀

BILL #	*SYNOPSIS WITH ISMS POSITION UNDERLINED*	*STATUS*
H-7A	Johnson-Amends Criminal Code, Code of Criminal Procedure, Unified Code of Corrections & Mental Health Confidentiality Acts; limits defenses based upon insanity, intoxicated and drugged condition; eliminates guilty but mentally ill verdict; provides for other prohibitions dealing with defendant's mental state. Oppose.	Tabled.
H-77	Braun-Amends Public Aid Code; provides that Dept. may restrict, not prohibit, reimbursement for any antimicrobial drug approved by the FDA, and that such drugs be included in the Dept. formulary. Oppose.	Signed by Governor P.A. 83-399
H-80	Braun-Amends Public Aid Code; provides that Dept. may restrict, not prohibit, reimbursement for any non-steroidal anti-inflamatory drug approved by the FDA. Oppose.	Signed by Governor P.A. 83-400

BILL #	*SYNOPSIS WITH ISMS POSITION UNDERLINED*	*STATUS*
H-222	Giorgi-Amends Optometric Practice Act; permits use of topical ocular pharmaceutical agents by qualified optometrists; requires referral of certain patients to doctors licensed to practice medicine in all of its branches. Oppose.	Tabled
H-343A	McCracken-Amends Civil Procedure Code; provides for offers of judgment for the settlement of claims before trial; defines costs but excludes attorney's fees. Under study since amended.	In Senate Judiciary I Committee
H-351A	Mulcahey-Amends School Code; permits chiropractors to certify condition of pupils for special activities or physical education. Oppose.	Signed by Governor P.A. 83-709
H-361A	Younge-Amends Public Aid Code & Purchasing Act; provides that Public Aid Code, in awarding bids for prepaid medical assistance contracts, shall give a 5% preference to Illinois bidders. Support.	Tabled
H-434	Preston-Amends Clinical Laboratory Act; permits licensed psychologists to order urinalysis and other noninvasive tests for pregnancy and drug use. Oppose.	Failed in House Committee.
H-621A	Terzich-Creates Disabled Child's Right to Treatment Act; requires health care facilities and professionals to report to Dept. of Children and Family Services the withholding of treatment or food from disabled minors; requires parents & guardians be provided with information on treatment & care alternatives. Opposed in current form.	Tabled
H-670A	Matijevich-Creates the Dept. of Substance Abuse which shall assume the duties and functions of the Dangerous Drugs Commission & alcoholism services in the Dept. of Mental Health & DD effective 7-1-84. Support.	Signed by Governor P.A. 83-131
H-713A	Pierce-Amends the Code of Civil Procedure & an act relating to interest rates; provides that judgments entered in cases filed after 6-30-83 shall bear interest at the rates certified semi-annually by the state treasurer to the courts administrator & such interest shall be compounded annually from the date of occurrence until the judgment is satisfied; in other cases, where judgment is entered after 6-30-83, interest shall accrue from date of judgment. Opposed.	Assigned to Interim Study House Judiciary
H-720A	O'Connell-Creates the Abortion Notice Act of 1983; provides that no person shall perform an abortion on an unemancipated minor or incompetent person unless notice has been given to parents or guardian. Under study.	Tabled
H-787A	Braun-Provides that no hospital, doctor or dentist or licensed professional health care provider may refuse to provide emergency treatment for a life-threatening problem. No opposition as amended.	Signed by Governor P.A. 83-723

BILL #	*SYNOPSIS WITH ISMS POSITION UNDERLINED*	*STATUS*
H-805A	Giorgi-Creates the Orthotist and Prosthetist Practice Act and establishes rules, regulations, licensing requirements and examining committee under Dept. of R & E. Support as amended.	Vetoed by the Governor
H-830A	Barnes-Amends Communicable Disease Prevention Act; provides compensation for injuries resulting from mandatory immunization for which no other compensation is available; creates Immunization Adverse Reaction Fund. ISMS legislation.	In Senate Public Health Welfare and Corrections Committee
H-928A	Jaffe-Amends Insurance Code, Non-Profit Health Care Service Plan, Medical Service Plan and Voluntary Health Services Plans acts; prohibits insurance companies and service plan corporations from making an independent determination that a claim under an accident and health insurance policy or service plan contract is medically necessary. Support.	In Insurance and Licensed Activities Committee.
H-942A	Ronan-Amends Definition of Death Act, Anatomical Gift Act & Vital Records Act; defines death as irreversible cessation of circulatory, respiratory & all functions of the entire brain. ISMS legislation. See S-984.	Assigned to Interim Study House Human Services Committee
H-952A	Ebbesen-Amends Optometric Practice Act; permits use of topical ocular pharmaceutical agents by qualified optometrists; requires referrals in some cases. Oppose.	Recommitted to Senate Insurance and Licensed Activities Committee
H-973	Ropp-Amends Public Aid Code; requires that public aid recipients pay, as co-payment for services, a fee of fifty cents for pharmacy services, one dollar for physician services and three dollars for hospital outpatient services. Oppose.	Assigned to Interim Study of House Human Services Committee
H-977A	Farley-Amends Pharmacy Practice Act; forbids prescription drug manufacturer or distributor to distribute a prescription drug directly or indirectly without charge or at less than fair market value. No position.	Signed by Governor P.A. 83-724
H-1030	Taylor-Creates the Medical Technologists Licensing Act; requires licensing by Dept. of R & E; provides qualifications, penalties, home rule. Under study.	Assigned to Interim Study of House Human Services Committee
H-1087	Pangle-Amends School Code; removes restriction that a physician conducting a required physical examination of school employees be licensed to practice medicine & surgery in all branches. Oppose.	Assigned to Interim Study of House Human Services Committee
H-1121A	John Dunn-Creates the Hearing Aid Consumer Protection Act; prohibits selling, fitting, dispensing or servicing hearing aids without certificate issued by Dept. of R & E; physician referral required. No position.	Amendatorily Vetoed. Overridden by both Houses.

BILL #	*SYNOPSIS WITH ISMS POSITION UNDERLINED*	*STATUS*
H-1168	Giorgi-Creates the Social Work Practice Act; licenses & regulates the occupation of social work; sets standards; creates examining board, repeals the Social Workers Registration Act. Under study.	Assigned to Interim Study of House Registration & Regulation Committee
H-1195	Kirkland-Amends Hospital Licensing Act; requires hospitals to allow staff privileges to licensed podiatrists subject to nondiscriminatory rules. Oppose.	Tabled
H-1299	Kulas-Amends Medical Practice Act; limits chiropractic practice to locating, analyzing and adjusting abnormal vertebral subluxations or misalignments interfering with the body's ability to retain or maintain health. Under study.	Assigned to Interim Study of House Human Services Committee
H-1354	Deuchler-Amends Nursing Home Care Reform Act and Ill. Nursing Act; permits medications to be administered by a medication technician who is supervised by a licensed nurse and has completed a state approved training program. Under study.	Assigned to Interim Study of House Human Services Committee
H-1435	Woodyard-Amends Public Aid Code and Ill. Income Tax Act; provides income tax credit for doctors rendering service to recipients who elect to receive an income tax credit in lieu of payment for such services. ISMS legislation.	Assigned to Interim Study of House Revenue Committee
H-1441	McAuliffe-Provides that the statute of limitations for medical malpractice actions shall not begin to run if person entitled to bring action is, at time action occurs, under 6 years of age. ISMS legislation.	Assigned to Interim Study of House Judiciary Committee
H-1462	Topinka-Amends Medical Practice Act; allows Dept. of Registration and Education to issue "visiting professor permits" entitling certain visiting faculty members who are licensed in another jurisdiction to practice in Illinois for a one year period. ISMS legislation.	Signed by Governor P.A. 83-97
H-1509	Steczo-Repeals acts providing regulations for the use of the drugs laetrile and chymopapain. ISMS legislation.	Signed by Governor P.A. 83-570
H-1548	Jaffe-Amends Civil Procedure Code; provides the claim of confidentiality may not be invoked to deny a patient access to data about his care when he is in a proceeding to decide whether he received acceptable standard of medical care; repeals certain contrary provisions. Oppose.	Assigned to Interim Study of House Judiciary Committee
H-1570	Keane-Permits nurses to make medical diagnoses and prescribe therapeutic or corrective measures under joint rules promulgated by the Board of Opinions on Professional Nursing & Committee on Nurse Examiners. Oppose.	Assigned to Interim Study of House Human Services Committee

BILL #	*SYNOPSIS WITH ISMS POSITION UNDERLINED*	*STATUS*
H-1621	Hicks-Amends various acts to provide liens for hospitals, physicians & dentists who treat injuries & diseases covered under the Workers Comp. & Occupational Diseases Acts. ISMS legislation.	In House Labor Committee Assigned to Interim Study
H-1726	Terzich-Amends Public Aid and Civil Administrative Codes; provides for a Hospital Medicaid Negotiator in the Dept. of Central Management Services, appointed by the governor, to contract for hospital services for medical assistance article of public aid code; other provisions. Oppose.	Assigned to Interim Study House Human Services Committee
H-1823	Hallock-Amends Code of Civil Procedure; provides that certain full benefit amounts payable to person by the unintentional wrongful acts of a hospital or doctor, less certain premiums paid for such benefits, shall be automatically deducted from any judgment awarded to the person against that hospital or doctor, except under certain conditions. ISMS legislation.	In House Judiciary Committee Assigned to Interim Study
H-1824	Vinson-Provides that a defendant who wins in any civil case, other than by settlement, has the right to actual and punitive damages against the plaintiff and the attorney, if the case was brought with a wilful and wanton disregard of the alleged facts. ISMS legislation.	Assigned to Interim Study of House Judiciary Committee
H-1938A	Topinka-Amends the State Employees Group Insurance Act. Provides that member coverage for out-patient psychiatric care shall be 50% of the fee charged, or $25, whichever is less, for a maximum of 20 visits per fiscal year. Oppose.	Assigned to Interim Study House Insurance Committee
H-2023	Curran-Creates the Living Will Act; provides method for terminally ill persons to authorize the discontinuance of medical treatment. Oppose.	Signed by Governor P.A. 83-824
H-2029	Ronan-Amends Professional Boxing & Wrestling Act; allows physician at boxing contest to stop contest to examine a boxer, and to terminate the contest if deemed necessary. ISMS legislation.	Signed by Governor P.A. 83-398
H-2086	Oblinger-The Geriatric Medicine Assistance Act; creates commission to receive & approve applications for grants from recognized medical & nursing schools to finance geriatric medicine programs in the schools. Under study.	House Committee on Aging Assigned to Interim Study.
H-2212	Bowman-Amends various acts to require Dept. of Public Health to develop standards to review high risk pregnancies and childbirths to identify developmental disabilities for purposes of referral & counseling. No position.	Signed by Governor P.A. 83-763

BILL #	*SYNOPSIS WITH ISMS POSITION UNDERLINED*	*STATUS*
S-61A	D'Arco-Creates Uniform Parentage Act; provides that any child born to a husband and wife consenting to the use of artificial insemination shall be considered at law to be a naturally conceived legitimate child. ISMS Amendment Adopted. No Position.	Amendatorily Vetoed. Sustained by both Houses.
S-87A	Rock-Amends Code of Civil Procedure & Interest Rate Act; establishes method of determining interest rates on certain judgments before & after 6-3-83. Oppose.	Defeated in Senate
S-92	DeAngelis-Amends Civil Administrative Code; eliminates requirement for psychiatrist director of Mental Health & Developmental Disabilities. Oppose.	Tabled in House.
S-123	Berman-Establishes the Cancer Treatment Act; Provides that only those persons licensed to practice medicine in all its branches, podiatrists and dentists may treat cancer. No opposition as amended.	Signed by Governor P.A. 83-286
S-163	Lemke-Creates the Counselor Registration & Licensure Act; provides for regulation & licensing of the counseling business. Oppose in current form.	In Senate Insurance Committee
S-369	Lemke-Creates Newborn Infant Protection Act; prohibits denying a newborn child food, water, or oxygen for any reason. Opposed in current form.	In Senate Executive Committee
S-400A	Egan-Amends Dental Practice Act; dentists with the approval of the hospital medical staff may perform histories & physicals prior to surgery. Under study.	Assigned to Interim Study House Registration & Regulation Committee.
S-440A	Marovitz-Amends Abused Child Reporting Act; requires medical, public health or nursing personnel having cause to believe a child under age 13 may be carrying a sexually transmitted disease to have a sexual assault examination conducted on the child by a licensed physician. Support.	Vetoed.
S-450A	Bruce-Amends Optometric Practice Act; permits use of topical ocular pharmaceutical agents by optometrists, qualified by education & certification, and requires the referral of certain patients to a physician. Opposed.	Tabled.
S-455	Dawson-Amends Hospital Licensing Act; requires IDPH to adopt rules & standards for determining when the public interest requires emergency action to terminate research programs or experimental procedures conducted by hospitals. No position.	Signed by Governor P.A. 83-255
S-495	Bloom-Creates Hospital Revenue Act; establishes revenue limits for hospitals from which patient charges are derived; Insurance Dept. to monitor the limits; provides for hospital hardship relief program. Oppose.	On 3rd reading in the Senate

BILL #	*SYNOPSIS WITH ISMS POSITION UNDERLINED*	*STATUS*
S-543	Coffey-Amends Vehicle Code; provides that person administering blood or urine tests is immune from liability except for gross negligence. Support.	Tabled
S-660	D'Arco-Amends Civil Procedure Code; reverses changes effected by P.A. 82-541; excludes reports of medical staffs of hospitals from confidentiality; other provisions. Oppose.	In Senate Judiciary I Committee
S-794	Holmberg-Creates the Insect Sting Or Bite Emergency Treatment Act; authorizes IDPH to certify persons who have completed training program to administer epinephrine in an emergency situation when a physician is not immediately available to treat person suffering a severe adverse reaction to a sting or bite. Support.	Amendatorily Vetoed. Sustained by both Houses.
S-920	Grotberg-Amends Insurance Code; requires coverage of chelation therapy under accident and health policies. Oppose.	Tabled
S-969	Bruce-Provides that prevailing defendant in civil case has cause of action for actual and punitive damages against plaintiff and plaintiff's attorney when wilful and wanton disregard of facts alleged can be shown. ISMS legislation.	In Senate Judiciary I Committee
S-983	D'Arco-The Occupational Therapy Practice Act; sets standards for licensure & regulation of registered occupational therapists & certified occupational therapy assistants. No Position.	Signed by Governor P.A. 83-696
S-1132	Luft-Amends Medical Practice Act; requires entities which seek to indemnify professional liability of practitioners to report settlements of claims in favor of plaintiffs to the State Medical Disciplinary Board. ISMS legislation.	Signed by Governor P.A. 83-860
S-1171	Newhouse-Amends Comprehensive Health Planning Act; changes Statewide Health Coordinating Council to Illinois Health Planning Council; provides for various directors of state agencies and various medical interest representatives to be appointed to the council. Oppose.	In Senate Executive Committee
S-1187	Schaffer-Requires Dept. of Public Health to promulgate rules requiring every newborn baby to be tested for galactosemia. No position. (Ill. Acadamy of Pediatrics supports)	Signed by Governor P.A. 83-87
S-1191	Bloom-Amends Acts relating to licensing of occupations; repeals state mandated continuing medical education. Support.	Signed by Governor P.A. 83-863
S-1328	Vadalabene-Creates the Corneal Transplant Act; coroners may authorize removal of corneal tissue for a transplant under certain conditions. Support as amended.	Signed by Governor P.A. 83-699

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Abstracts of Board Actions

(Continued from page 386)

MANDATORY REPORTING

Amendments to the Medical Practice Act to include mandatory reporting of physician discipline were effective January 1, 1983. Rules and regulations implementing the law were promulgated in May. In order to assist the membership in addressing this issue, and in cooperation with the Illinois Hospital Association, Chicago Medical Society and Chicago Hospital Council, a booklet guide to the mandatory reporting requirements was developed. This guide should provide information necessary to assure that there is uniformity of interpretation of the new law and ease any burden caused by the reporting requirements. A series of questions and answers appended to the guide provide examples of process.

The Board endorsed the booklet, authorized its publication in *IMJ,* and directed that it be printed and distributed to all county medical societies and hospital medical staffs in Illinois.

UCR VERSUS INDEMNITY

The American Medical Association House of Delegates in June, 1983, received a report from its Council on Medical Services on payment for physician services. In essence the report calls for review of the use of the Usual, Customary and Reasonable concept in reimbursement of physicians by third party payors. The alternative would introduce the concept of idemnity by which the patient is responsible for the professional fee as agreed with the physician, and the third-party payor would reimburse the patient.

Existing ISMS policy embraces UCR as the preferred mechanism of physician payment by insurance carriers. Thus, this issue warrants thorough discussion. The American Medical Association intends to open this issue for review at the Interim Meeting, December, 1983. In review and response to this, the Board directed:

- The Illinois Delegation to the AMA to recognize existing ISMS policy on UCR and attempt to delay any action by the AMA until the June, 1984, meeting (to allow full discussion by the ISMS House of Delegates).
- That the membership be informed of this proposed change and a session be scheduled at the Leadership Conference to review the issue.
- That this matter be considered at a session of the ISMS House of Delegates.

COMMITTEE ON DRUGS & THERAPEUTICS

The Board approved the following drug products for inclusion in the Illinois Department of Public Aid Drug Manual: Depakote (Divalproex Sodium)-250 & 500mg enteric coated tablets; Zantac (Ranitidine HCl)-150mg tablets; Mycelex (Clotrimazole)-10mg troche; Chenix (Chenodiol)250mg tablets; Inderal (Propranolol HCl)-60mg tablets—New Strength; Proventil Inhaler (Albuterol Sulfate)-90mcg/spray—New Dosage; Nasalcrom (Cromolyn Sodium)40mg/ml nasal solution—New Dosage; and Trisoralen Tablets.

The Board also recommended that the following drugs not be included in the Drug Manual: Pedialyte RS (Oral Electrolyte Solution); Loprox (Ciclopox Olamine); BetaVal (Betamethasone Valerate); Inderal La (Propranolol HCl)-80, 120 and 160 mg capsules—New Strength; Bricanyl Inhaler (Terbutaline Sulfate)-0.2mg/inhalation—New Dosage; Humulin R (Human Insulin) regular-100 units/ml; Humulin N (Human Insulin NPH) 100 units/ml; Netromycin (Netilmicin Sulfate) 20, 50 & 100 mg/ml inj.; Eloxyl-5 and 10 Water Based Gel; Eldoquin-Forte 4% Cream; Eldopaque-Forte 4% Cream; Solaquin-Forte 4% Cream; Benoquin 20% Cream; Oxsoralen Capsules and Lotion 1%; Psoranide Cream 0.025%; and Fototar Cream.

The Board further recommended that: (1) Halcion be restored to the Illinois Department of Public Aid Drug Manual, for recipients in Long Term Care Facilities; and (2) Asendin and Minocin not be recommended for inclusion in the Illinois Department of Public Aid Drug Manual.

The Board referred back to the Committee on Drugs & Therapeutics for reconsideration, the recommendation that the drug product Dalmane be removed from the Illinois Department of Public Aid Drug Manual.

EXECUTIVE SESSION

The Board met in executive session. Rising from executive session, the Board resolved that ISMS General Counsel, with the advice, consent and direction of the Chairman of the Board of Trustees, the President, President-Elect and Executive Administrator, supervise and guide legal counsel efforts in *Wilk, et.al., v. AMA, ISMS, et.al.,* for the purpose of exploring legal options on behalf of Illinois State Medical Society. Specifically, ISMS General Counsel, with the advice, consent and direction of the Chairman of the Board of Trustees, the President, President-Elect and Executive Administrator, shall, if appropriate, cause a petition for rehearing *en banc* to be filed with the United States Court of Appeals for the Seventh Circuit. Action taken by legal counsel will be reported to the Board of Trustees.

POLICY COMMITTEE

Upon recommendation of the Policy Committee, based upon actions taken by the House of Delegates at its 1983 annual meeting, the Board approved the following policy statements for inclusion in the Policy Manual.

New Policies

- Diagnosis Related Groups (Res. 36 A-83)
- Joint Commission on Accreditation of Hospitals (Sub. Res. 2 A-83)
- Animals in Research and Education (Res. 30A-83)

Amendments to Existing Policies

- Seatbelt Use (Res. 7 A-83)
- Resident Physician Membership (Res. 19 A-83)
- Emergency Care, Provision of (Res. 5 A-83)
- Continuing Education (Res. 16 A-83)
- Peer Review (Report F A-83- Res. 18 I-82) (See Chapter XII of the Bylaws)

The Board further approved the following actions:

- *Professional Liability* (Res. 10 A-83)
  That this resolution not be adopted as policy and an Old Business Report be submitted.
- *Cost Containment* (Res. 4 A-83)
  Referred this resolution to the Medical Legal Council.
- *Rape Victims* (Res. 25 A-83)
  Directed Sub. Res. 25 (A-83) be referred to an appropriate council to develop definitions of essential elements of a rape victim counseling program to enable the Policy Committee to prepare an appropriate policy statement for publication.

OTHER ACTIONS

In addressing various other issues, the Board:

- Ratified supporting SB 400 and initiating an effort with the Illinois State Dental Society to establish guidelines for assisting hospital medical staffs considering granting privileges for dentists.
- Agreed to continue joint billing for IMPAC/AMPAC for 1984.
- Ratified a $45 registration fee for the Leadership Conference Program in November to cover unbudgeted costs of about $9,500.
- Discharged the Building Committee with commendation for its excellent accomplishments; and approved appointing a permanent Capital Building Committee to' insure continuity of Society's needs, and that this recommendation be incorporated into a HOD resolution.
- Agreed to accept a Council on Medical Services' report and comments on the most recent proposed revision of the Medical Staff chapter for the JCAH Accreditation Manual for Hospitals, after legal counsel review.
- Directed that ISMS meet with the Illinois Chapter of American College of Emergency Physicians and Illinois Department of Public Aid, in order to continue negotiations on IDPA's outpatient hospital reimbursement policy.

- (A) Authorized staff and legal counsel to work with the Department of Insurance to review potential hold harmless problems in Illinois; (B) Instructed legal counsel to consider the appropriateness of approaching individual insurance carriers for input into their reimbursement methodologies and hold harmless policies without violating any existing FTC regulations; and (C) Authorized legal counsel to, where appropriate, provide Illinois State Medical Society members who request it, assistance in hold harmless litigation in which said member is a party.
- Directed that ISMS formally communicate objections to the Illinois Department of Public Aid on the Ambulatory RFP.
- Directed that the Society invite the Illinois Hospital Association, Chicago Hospital Council and Ill. Department of Transportation to a meeting to discuss the advantages of a hospital having its own heliport.
- Referred to legal counsel Substitute Resolution 35 (A-83) which resolves that "ISMS create legislation defining criteria for equipment, staffing and treatment capabilities which must be met before a facility providing patient care can use the word 'emergency' or any derivation thereof in its advertising or its name."
- Approved: (1) With commendation, The "Guide to Hospital Medical Staff Bylaws"; (2) Its publication in the *Illinois Medical Journal;* (3) Mailing the "Guide" to all county medical societies and Medical Staffs; and (4) Reprinting the "Guide" for sale to others upon request.
- Referred to legal counsel a council recommendation pertaining to the AMA's right to develop guidelines which protect the quality of care provided to patients.
- Authorized: (1) An increase in *IMJ* foreign subscriptions to $19 per year beginning with the January, 1984, issue; and (2) Maintaining current membership subscription rates for 1984.
- Approved legal counsel review of the following *Journal* issues: (1) What authority and responsibility are implied in our mandate to review *IMJ* advertising; (2) What standards could be established for review of copy submitted; (3) Within what parameters should the committee evaluate the veracity and suitability of proposed advertisements; and (4) What level of concern or error could justify refusal of a proposed advertisement.
- Endorsed an ISMS "Guide to Due Process" and authorized: (1) Its publication in the *IMJ;* (2) Its printing and distribution to county medical societies and medical staffs; and (3) Its sale to other interested parties upon request.
- Authorized that: (1) Staff develop an educational brochure on PPOs for ISMS members; (2) PPOs be addressed at the November ISMS Leadership Conference in Decatur; and (3) Legal counsel be instructed to develop a set of guidelines to be used by individual members and county medical societies in negotiations with their attorneys and representatives of institutions seeking to develop PPOs in Illinois communities.
- Adopted the following positions: (1) That the State of Illinois be encouraged to continue to support funding of primary care residency programs to meet the State's ongoing need for medical manpower; (2) That funding for the Family Practice Residency Act be restored through the Illinois Department of Public Health at levels sufficient to maintain previously established programs; and (3) That efforts of the Board of Higher Education to support primary care residency programs and seeking additional funds for supporting nonpublic as well as public residencies, be commended and such support be communicated to the State legislature and the Office of the Governor.
- Approved using a $9,438.60 reimbursement from the American Medical Association for non-member recruitment at the county society level.
- Approved various legislative positions with respect to primary bills.

In addition, the Board directed that the definition of death legislation previously introduced in the General Assembly in compliance with the House of Delegates policy not be reintroduced in the next session of the Illinois General Assembly in light of a recent Appellate Court ruling. This particular ruling contains language

that is very similar to the ISMS House of Delegates policy on definition of death.

- Agreed to provide ISMS staff support for the activities of the Illinois Delegation to the AMA Hospital Medical Staff Section.
- Authorized that: (1) $50,000 be released from the Illinois State Medical Society student loan fund account for the purpose of providing student loans to eight Illinois medical schools for academic year 1983-84 in the following increments: Univ. of Chicago, $6,200; Loyola University, $6,200; Rush Medical College, $6,400; Chicago College of Osteopathic Medicine, $4,800; Northwestern University Medical School, $7,100; University of Illinois, $8,200; Southern Illinois University, $2,500; and Chicago Medical School, $8,600; and (2) Interest rates be set for the above loans at 5.5% to allow for basic administrative costs of the program.

APPOINTMENTS/NOMINATIONS

Acting upon recommendations of the councils and Executive Committee, the Board:

- Nominated the following to serve on the Illinois Department of Public Aid's Full Service Capitation RFP Review Committee: Drs. James H. Andersen, Oak Brook; Lorris Bowers, Peoria; James Durham, Benton; William Fish, Chicago; Charles Frazer, E. St. Louis; Orland W. Pflasterer, Coulterville and Hugo Velarde, Highland Park.
- Ratified the following council/committee appointments: Dr. Andrew Griffin, Maywood, to: (1) Citizens Advisory Committee on Alcoholism and (2) Committee on Alcoholism and Drug Dependence; Dr. Simon Zivin, Chicago, to the CME Accreditation Committee; Dr. Sara Charles, Chicago, to the Loss Prevention Committee; Dr. Hubert Allen, Chicago, to the Health Professions Committee; Dr. Audley F. Connor, Jr., Chicago, to the Joint Practice Committee.
- Added Drs. Larry C. Gunn, Hinsdale, and Edward A. Wolpert, Chicago, to the *IMJ* Editorial Board.
- Endorsed nominations of Dr. LeRoy P. Levitt for the Distinguished Service Award; Dr. Joseph B. Kirsner, for the Scientific Achievement Award; and Dr. Eric Oldberg, for the Benjamin Rush Award.
- Appointed Dr. Donal O'Sullivan chairman of the Medical Legal Council to replace Dr. Robert Sumner, who resigned.

PROGRAMS AND SYMPOSIA

The Board:

- Agreed to extend the Society's cooperation in the medical aspects of the Prairie State Games being held in April of 1984 by the Governor's Council on Health and Fitness. (No funding necessary)
- Commended all those who took part in the ISMS-sponsored programs on Diagnosis Related Groups (DRG).
- Agreed to co-sponsor the IHA's Administrator—Medical Staff—Trustee Strategic Management Team project contingent upon ISMS approval of physician faculty and program content.

OTHER MATTERS

The Executive Administrator announced a ruling by the Illinois Supreme Court that determined that the trial court does have the authority under the legal doctrine of *forum non conveniens* to transfer venue of a case.

Additionally, during the meeting, word was received from the Governor indicating he had signed the bill repealing mandatory CME requirements as a condition of license renewal.

A new membership slide program was presented for viewing by the Board of Trustees. This is available through the Division of Membership.

Viewbox

(Continued from page 418)

Diagnosis: Multicystic Dysplastic Kidney

Multicystic dysplastic kidney is the most common abdominal mass among newborns.[1,2] Hydronephrosis, not given as a diagnostic choice, becomes most common when older neonates and infants are considered along with newborn infants. The multicystic dysplastic kidney consists of a grape-like cluster of cysts. It is accompanied by atresia or hypoplasia of both the ureter and renal vessels. The appearance on excretory urography and ultrasonography is often distinctive but may sometimes closely resemble congenital hydronephrosis.[3,4]

Infantile polycystic kidney disease is a bilateral abnormality. It differs greatly from adult polycystic disease in that it is transmitted as an autosomal recessive, occurs in the infant, and is accompanied by hepatic fibrosis. No gross cysts are seen on excretory urography or ultrasonography. Microcysts, however, cause a striated appearance of the nephrogram on urograms and increased echoes on sonography.

Fetal renal hamartoma and Wilms' tumor have similar radiographic appearances. Both are solid, not cystic, masses. The hamartoma is the most common renal tumor in the neonate and is much more common than Wilms' tumor in that age group. It must be identified by pathologic charac-

Table 1

Abdominal Masses—First 2 Days of Life*

Renal	
Multicystic Dysplastic Kidney	20
Hydronephrosis	10
Wilms' tumor**	4
Polycystic Kidney	3
Renal vein thrombosis	1
Ectopic kidney	1
Gastrointestinal	
Intestinal duplication	3
Meconium ileus	2
Omental, mesenteric cyst	2
Malrotation, volvulus	1
Dilated ileum proximal to atresia	1
Genital	
Hydrocolpos, hydrometra	9
Ovarian cyst	6
Liver	
Liver cyst	2
Hepatoma	1
Retroperitoneal	
Neuroblastoma	5
Teratoma	2

**Modified from Griscom, N.T.: "The Roentgenology of Neonatal Abdominal Masses," Am J Roentgenol 93:447-463 1965.*

***These were probably fetal renal hamartomas. The two were not recognized as separate lesions at the time this study was done.*



Figure 3

This 48 year old man had a duodenal ulcer. These cresentic calcifications (arrows) in the right upper quadrant were identified on a plain radiograph of the abdomen. An excretory urogram showed only a normal but enlarged left kidney. Sonography showed a cluster of cysts in the right renal fossa. Because of the characteristic appearance of a multicystic dysplastic kidney, no further studies were done.

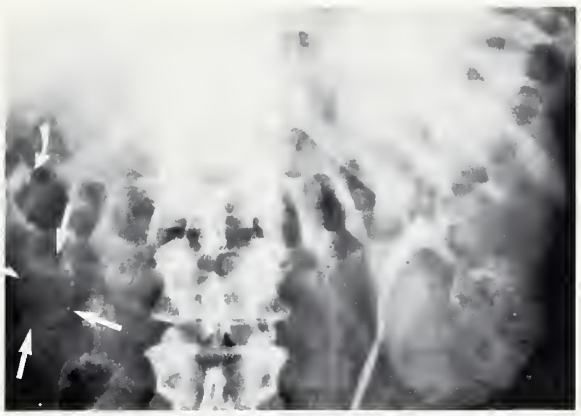


Figure 4A



Figure 4B

This 19 year old man had gallbladder disease. (A) On a gallbladder examination these calcifications in the right upper quadrant were seen. Sonography showed gallstones, but the calcifications were in the renal fossa. (B) Excretory urography shows an enlarged left kidney only. Calcifications (arrows) are seen but there is no opacified right kidney tissue. A cholecystectomy was done and the kidney was removed at the same operation. The kidney was replaced by 0.8-6cm thin walled cysts. There was minimal connective tissue. The renal artery was rudimentary. The ureter was patent but had a minute lumen.

teristics. Prognosis following resection is excellent.

Renal vein thrombosis in the neonate is rare and is usually a complication of dehydration associated with diarrhea, infection, sepsis, or blood loss. Infants of diabetic mothers have an increased incidence of renal vein thrombosis. The kidney would be enlarged with renal vein thrombosis, but the calices would be compressed by intrarenal edema or hemorrhage, not dilated. It is noteworthy that echo-free areas simulating cysts on sonography have been described in renal vein thrombosis. This finding has been attributed to focal edema or hemorrhage.[5]

Multicystic Dysplastic Kidney

This congenital anomaly is the most common renal mass discovered in the first few days of life (Table 1). It may go undiscovered, however, until adulthood. In adults the multicystic dysplastic kidney is usually discovered by chance when characteristic calcifications are identified on plain radiographs of the abdomen performed for unrelated problems. We discovered three such adults during a one year time interval (Fig. 3-5).

Involvement of both kidneys with early death, segmental involvement of one kidney, and a lesion in a horseshoe kidney have been reported.[6] Unilateral disease seldom causes symptoms except for mass effect in neonates, but some patients have anomalies of the contralateral kidney.

Pathology

The kidney is replaced by multiple cysts varying from millimeters to centimeters in diameter. There is only a small amount of solid tissue consisting of mesenchymal tissue, cartilage, dystrophic glomeruli and atrophic tubules. The ureter or renal pelvis is atretic and the vascular pedicle atretic or hypoplastic. Prognosis is better when the ureter is atretic near the renal pelvis so that the blind ending ureter is long. When the atresia is close to the bladder so that the ureteral remnant is short, there is a higher incidence of contralateral renal lesions, most often another multicystic dysplastic kidney or ureteropelvic obstruction.[7] Most anomalies of other organ systems have been found in those with bilateral multicystic kidneys.

The etiology of the lesion has been attributed to an embryonic injury to the ureteral ampullae due to outflow obstruction or reflux and failure of normal ureteric budding. One hypothesis relates this renal lesion to fetal vascular occlusion similar to the mechanism accepted as the cause of congenital intestinal atresia. This theory suggests that the developing kidney migrates from the pelvis to the abdomen and acquires new vascular connections during the journey. If this vascular supply fails to develop, ischemia of the ureter causes ureteral atresia. This ureteral obstruction early in fetal development results in the multicystic dysplastic kidney, which is actually end stage hydronephrosis.[7]

Radiology

Plain radiographs of the abdomen may show mass effect in neonates or may show one or more

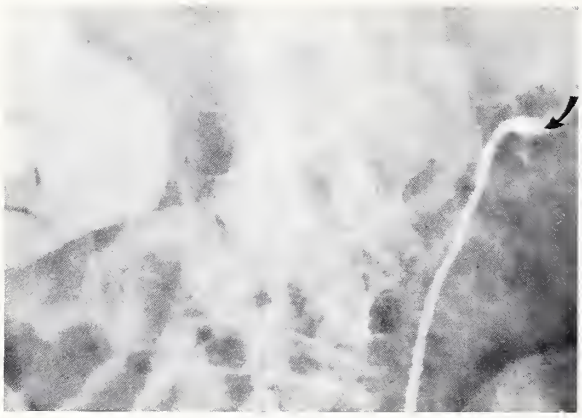


Figure 5A

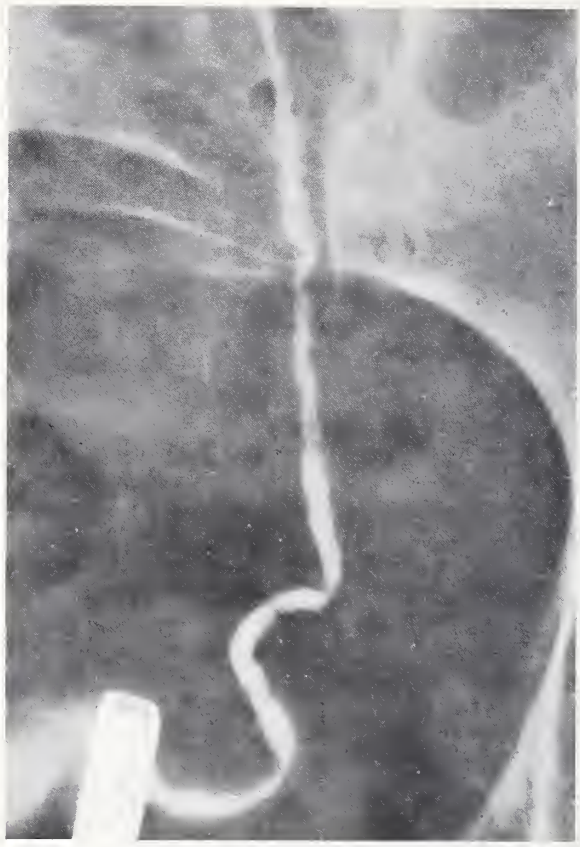


Figure 5B

This 67 year old woman had lymphocytic lymphoma. On a bone scan, absence of left renal activity was seen. Excretory urography showed right hydronephrosis but no excretion by the left kidney. (A) Retrograde pyelography shows a blind ending left ureter with a bulbous end (arrow). (B) Close up of the proximal left ureter shows a beaded appearance which has been described in multicystic dysplastic kidneys. The patient died and, at autopsy, the left kidney consisted of a single cyst. There was no left renal artery.

curvilinear or circular calcifications in the renal fossa of adults (Fig. 3-4).[8-11]

Excretory urography most often shows no opacification of the non-functioning multicystic dysplastic kidney which appears as a lobulated lucency. In some neonates, arcs of density occur within the lesion and have been attributed to total body opacification outlining cysts (Fig. 1).[12] A few patients, however, have had delayed appearance of contrast material *in* cysts, indicating at least minimal function.[13] In adults, and in some infants, there will be compensatory hypertrophy of the opposite kidney (Fig. 4).

Voiding cystourethrography may result in filling of the atretic ureter by reflux, but *retrograde pyelography* may be needed. Rarely, there is no ureteral orifice in the bladder. In some patients the atretic ureter has a typical beaded appearance and a bulbous proximal end (Fig. 5).[6,8] Rarely, the ureter has a minute patent lumen.

Angiography. The renal vessels may be absent or hypoplastic.

Ultrasonography. Multiple thin walled cysts are characteristic but may be indistinguishable from hydronephrosis (Fig. 2).[3,4]

Computed tomography shows a collection of cysts with little renal parenchyma.

Treatment

Excretory urography should be done to identify abnormalities of the opposite kidney. Nephrectomy has generally been the treatment in the past. It has generally been suggested that surgery is required because of mass effect or possible infection, rupture, or hypertension complicating the lesion. In some cases it may be felt that nephrectomy is required to make a certain diagnosis.

When a nonoperative diagnosis can be made in the neonate or adult, nonoperative management should be considered.[7]

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ISMS 1984 TRAVEL PROGRAMS

March 4-19—*South Pacific*
Australia, New Zealand and Tahiti

April 21-May 4*—*Spain/Portugal*
Lisbon, Seville, Costa del Sol and Madrid

May 29-June 11—*Europe*
Munich, Strasbourg and Lucerne, including the 350th Anniversary Performance of the Passion Play at Oberammergau

June 23-30*—*New England/Cape Cod Cruise*
Boston, Plymouth, Nantucket, Martha's Vineyard, Newport and New Bedford

August 4—*U.S. Canyon Lands***
Denver, Moab Arches, Bryce Canyon, Zion, Grand Canyon, Scottsdale

September 9-23—*Far East*
Tokyo, Kyoto, Singapore, and Hong Kong

October 12-26—*Danube River Cruise*
Austria, Czechoslovakia, Hungary, Yugoslavia, Romania, Bulgaria, Russia and Turkey

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS and auxiliary members at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators.
For further information, please contact the travel department at ISMS headquarters.

**Note change in date*
***New trip—Russia cancelled for 1984*

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC, National Academy of Sciences, 1980, p. 13.

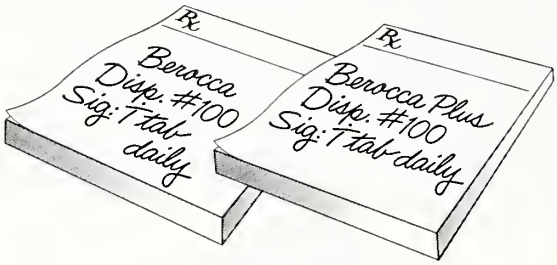
Please see summary of product information on reverse page.

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Before prescribing, please consult complete product information, a summary of which follows:
Each Berocca® tablet contains: 500 mg vitamin C (ascorbic acid), 15 mg vitamin B_1 (as thiamine mononitrate), 15 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 4 mg vitamin B_6 (as pyridoxine HCl), 18 mg pantothenic acid (as calcium *d*-pantothenate), 0.5 mg folic acid, 5 mcg vitamin B_{12} (cyanocobalamin)
Each Berocca® Plus tablet contains: 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha-tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide)
INDICATIONS: Berocca—Supportive nutritional supplementation in which water-soluble vitamins are required prophylactically or therapeutically, including conditions causing depletion, or reduced absorption or bioavailability of water-soluble vitamins, conditions resulting in increased needs for water-soluble vitamins. Berocca Plus—Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals
CONTRAINDICATIONS: Hypersensitivity to any component
WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
PRECAUTIONS: *General*: Certain conditions may require additional nutritional supplementation. During pregnancy, vitamin D and calcium supplementation may be required with Berocca Plus or supplementation with fat-soluble vitamins and minerals may be required with Berocca. Not intended for treatment of severe specific deficiencies. *Information for the Patient*: Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions*: As little as 5 mg pyridoxine daily can decrease efficacy of levodopa in treatment of parkinsonism. Not recommended for patients undergoing such therapy.
ADVERSE REACTIONS: Have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca and Berocca Plus. Allergic and idiosyncratic reactions are possible at lower levels. Iron, even at recommended levels, has been associated with GI intolerance in some patients.
DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Available on prescription only. (Berocca Plus is not recommended for children.)
HOW SUPPLIED: Berocca—Light green, capsule-shaped tablets—bottles of 100 and 500. Berocca Plus—Golden yellow, capsule-shaped tablets—bottles of 100

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Springfield Memo

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Public Health (IDPH)

Japanese Encephalitis Vaccine Availability and Testing

The Center for Disease Control is currently planning to offer Japanese Encephalitis vaccine as an investigational product to U.S. citizens traveling to or residing in Japan, the far eastern U.S.S.R., Korea, China, the Indian subcontinent and all of southeast Asia. The vaccine will be distributed by CDC under an Investigational New Drug (IND) exception issued by the Food and Drug Administration. Information on the vaccine may be obtained from the IDPH Division of Disease Control, Springfield, IL 62761.

In order to deliver the vaccine under an IND exception, co-investigators will be required to obtain informed consent, immunize the participants, keep records on adverse reactions and obtain pre- and post-immunization serologic samples from selected vaccines for antibody tests.

If you are interested in participating or can identify other co-investigators, please notify Robert Craven, Division of Vector-Borne Viral Diseases, P.O. Box 2087, Ft. Collins, Colorado 80522, and a formal protocol will be mailed to you.

IDPH Recommendations for Prevention of Hemophilus Influenzae Meningitis in Contacts to Cases

Rifampin is useful in prophylaxing close contacts to invasive *H. influenzae* disease. The American Academy of Pediatrics Committee on Infectious Disease has formulated recommendations on the subject. In a household or day care center where a case of invasive *H. influenzae* disease occurs, if children—other than the index case—less than four years old are present, rifampin should be given orally to all contacts once daily for four days in a 20 mg/kg dose (maximum dose, 600mg per day). This is the dose recommended for all household and day care center contacts, regardless of age, because of

their possible role in exposing children less than four years old. The Academy also recommends that therapy for children with invasive *H. influenzae* disease include rifampin (in the dose described above) because systemic antimicrobial therapy that successfully cures the disease may not eradicate nasopharyngeal carriage.

Pediculosis Recommendations

IDPH has recently revised recommendations for the control of pediculosis. Copies are available from your local health department of IDPH. These recommendations emphasize the importance of a second shampoo treatment seven to ten days after the first treatment, in accordance with advice from the CDC. According to CDC, pediculicides licensed for use in the United States have not yet been proven to be ovicidal when used according to manufacturer's instructions.

Reye Syndrome Update

Studies cited in the CDC *Morbidity and Mortality Weekly Report* from several states have revealed a strong association between the administration of salicylates to children with chicken pox and influenza and the subsequent development of Reye syndrome. The CDC, IDPH, the Surgeon General, and the AAP have all adopted policies discouraging the use of salicylates and salicylate-containing compounds to children suspected with either of these diseases.

Reye syndrome became a reportable disease in Illinois on January 1, 1982. Each case must be reported to the city or county health department where the physician practices or, if there is no local health department, directly to IDPH. The patient's name, address, telephone number, age, sex, race and date of onset, as well as the name and address of the physician and hospital, are required.

From the Department of Aging

Nursing Home Prescreening Program

Effective July 15, 1983, nursing home prescreening was initiated statewide for elderly and disabled clients. The Department on Aging reports that in the first two weeks of the initiative, designated case coordination units, working with hospital social service departments, screened 645 persons over the age of 60 headed for nursing homes, and linked 51 of them with community services. Case coordination units report a large number of "pending" cases, as persons in need of community based services await the required physician approval. Physicians receiving requests for approval of community care program services are urged to contact the case coordination unit indicated on the form if they need further information to complete the document.

From the Department of Registration and Education (R&E)

Requirements for Dispensing and Administering Controlled Substances

Inspections of physicians' offices by the Department of Registration and Education (R&E) drug compliance office have revealed that many practitioners are unaware of state laws mandating specific procedures and records for dispensing and/or administering controlled substances.

Essentially, the rule requires the use of a Patient Controlled Substances Record (PCSR) whenever a physician administers a designated product, administers or dispenses non-designated Schedule II controlled substances, or dispenses Schedule III, IV and V controlled substances.

The PCSRs are to be arranged alphabetically by the patient's last name and maintained in one place. The record must contain the following information:

—Date of dispensing or administering;
—Name of the controlled substance;
—Quantity dispensed or administered; and
—Name or initials of the individual who dispensed or administered the controlled substance on behalf of the physician, if not personally dispensed or administered by the doctor.

Additionally, when a physician dispenses a designated product, this act must be recorded on a state triplicate prescription blank. A legible duplicate must be mailed to R&E by the 15th of the month following that in which the product was dispensed. The original must be maintained for two years and kept separate from the blanks recording actual prescriptions.

Prescription blanks required for such dispensing must be marked with a "D" in the upper right hand corner. Failure to comply with the above requirements is considered a violation of the Medical Practice Act.

Further information on this can be obtained from Lawrence B. Slotnik, Drug Compliance Coordinator, R&E, 17 N. State, 17th Floor, Chicago, IL 60602. ◀

Illinois Society, American Association of Medical Assistants

The Role of The Physician Advisor

By Lesa B. Greene, CMA-C

Traditionally, physicians have served in an advisory capacity at the three levels of the American Association of Medical Assistants. The general qualifications for participation include membership in the American Medical Association, as well as an interest in working toward "the welfare and betterment of the A.A.M.A."

Through interaction with A.A.M.A. member-employees, physicians are selected by local chapters to serve in an advisory role. As advisors, these physicians are encouraged to attend all local meetings and occasionally are asked to present a program.If the physicians cannot attend a function, they are still included in all local mailings and kept current on local activities.

After gaining experience as a local advisor, physicians may choose to serve in a state level capacity. The Illinois Society advisory board consists of "physicians who are members of the Illinois State Medical Society; one is appointed by ISMS as Liason, and the others are elected by the Illinois Society House of Delegates. The tenure of office of those elected is three years on a rotating basis, and the Board elects its own chairman and secretary."

The chairman of the ISMS advisory board is John L. Wright, M.D., and fellow board members are: Thomas Harwood, M.D., Robert R. Hartman, M.D., ISMS Liason, Leslie Schwartz, M.D., Peter C. Lee, M.D. and Robert E. Thompson, M.D. These members have maintained their board status for varying terms of office, and all areas of the state are represented.

Allison L. Burdick, Sr., M.D., was a member emeritus of the physician advisory board until his death in September. We shall miss his kindness and counsel.

Members consider their role on the advisory board to be important and rewarding. Many of the physicians have commented that feedback from these meetings has resulted in improved office efficiency. In addition, they have developed a better awareness of the dedication and enthusiasm of their medical assistants. Each of the advisors encourages colleagues to participate in A.A.M.A. functions. As one member stated, "Involvement with the A.A.M.A. can be nothing but a positive experience."

As a member of the national advisory board, physicians "shall have had experience as a local and/or state advisor, so that they are familiar with the goals and objectives of the association. The president of the A.A.M.A. appoints each advisor as consultant to one or more national committees. It shall be the advisors' duty and responsibility to support the policies of A.A.M.A., promote membership, provide liason with their respective state medical societies, and provide other advice and counsel at all times whenever the occasion demands it or is requested of them." If physician-advisors are interested in a national-level position, their state society will nominate them to the advisory board.

Information regarding the position of physician-advisor may be obtained by writing: John L. Wright, M.D., chairman, 2416 East Washington Street, Suite A, Bloomington, IL, 61701; Betty Kronemeyer, CMA, president, Illinois Society, 809 North 10th Street, Mascoutah, IL, 62258, or contacting the local A.A.M.A. chapter presidents. ◀

Medical News

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The anti-oxidant sulfiting agents have been used in drugs and foods to retain freshness. They are most often used in restaurant salad bars, seafoods, fried potatoes, and various drinks. The Food and Drug Administration has received reports of adverse reactions including flushing, angioedema, hives, laryngeal edema, hypotension, cyanosis, wheezing, itching, anaphylaxis, loss of consciousness, respiratory arrest and dermatitis. Reactions have been produced by challenges of oral sulfites as low as 5mg and inhalation of sulfur dioxide 1ppm in air for 10-30 minute periods. Bronchospasm may result with exercise stress at levels of 6ppm. Physicians should remind allergic individuals to read food labels and ask restaurants whether sulfiting agents are used. (*FDA Drug Bulletin* Vol. 13: 2, 11-12, Aug. 1983)

Dr. L. Z. Rubenstein suggests monitoring geriatric patients with increased incidence of falling injuries by evaluating the carotids, neurologic dysfunctions and urinary problems, orthostatic hypotension, changes with head turning, vertigo and cardiac monitoring for dysrhythmias. Appropriate therapy may include antiarrhythmics or pacemakers, restoring hemodynamic stability, shoe modifications, canes or walkers. Hypotensive episodes may be ameliorated by bedrest with head elevated, elastic stockings to reduce venous pooling in the legs, cervical collars for vertebrobasilar insufficiency associated with head motion and hearing and visual corrections as needed. (*West J Med* 138:273-5 Feb. 1983)

Mild hypothyroidism may cause hypertension in women over 50, according to a study by Dr. I Saito, *et al.* Blood pressure readings in excess of 160/95 mmHg were considered hypertensive cases, and 14.8% of hypothyroid women fell into this category as compared to an hypertensive episode rate of 5.5% in euthyroid women. (*Hypertension* 5:112-5 Jan-Feb 1983)

Methods to identify patients at high risk for future cardiovascular events have intrigued epidemiologists for decades. Dr. W.B. Kannel has evaluated the vital capacity in women and their cardiovascular morbidity. The forced vital capacity adjusted for age, cigarette smoking, hypertension and other risk factors may be a sensitive indicator of impaired cardiac function, particularly heart failure. (*Am Heart J* 105:311-5 Feb 1983)

Psychosocial factors, particularly stress, appear to enhance coronary arteriosclerosis in Macaca monkeys even when serum lipid levels, BP, serum glucose, and ponderosity were equal to non stressed control monkeys. This may explain the severe coronary artery disease in persons with normal values for risk factors. (Kaplan, J.R., *et al: Science* 220:733-5, 1983)

Emotional difficulties, shyness and interpersonal problems, visuospacial disturbances and paralinguistic communicative disabilities in patients of average intelligence who report academic arithmetic problems may indicate right hemisphere dysfunction. These patients generally avoided eye contact and showed lack of gesturing. Many gave family histories of similar problems. These syndromes are contrasted to the left hemisphere dyslexias. Brain damages resulting in these manifestations generally occur early in life, or because of heredity. These patients should have a neurological and neuropsychological work-up. (Weintraub, S., Mesulam, M.: *Arch Neurol* 40:463-8, Aug 1983)

The incidence of hypertension in male Harvard alumni was studied between 1962 and 1972, and in another group, from 1966 to 1972. Alumni who did not engage in vigorous sports play were at 35% greater risk of developing hypertension than were those who did. Men 20% or more over ideal weight for height were at 78% greater risk than lighter men. An hypertensive parent increased the risk 83%. The beneficial effects of vigorous exercise may be in the body fat content reduction. (Paffenbarger, R.S.: *Am J Epidemiol* 117:245-57, 1983)

Dr. M. Moskowitz suggests that mammography rather than clinical thermography and physical examinations are the best procedures at present for breast cancer. Histologic diagnosis may be enhanced by aspiration biopsy from bloody nipple discharges, nipple ulcerations, crusts and eczema. He reports that 16% of minimal breast cancers would have been missed had physical examination been omitted, and 63% had mammography been omitted. (*CA* 33:26-29, Feb 1983)

Low blood glucose levels may be erroneously reported by the autoanalyzers in patients with polycythemia vera whose blood is not analyzed immediately post venopuncture. Time lag between drawing of blood and the lack of use of inhibitors

permit rapid vitro glycolysis with false severe hypoglycemic reports in cases with myeloproliferative disorders. (Billington, C.J. *et al: JAMA* 249:774-5, Feb 1983)

Meticulous clinical supervision is required in patients who are to be withdrawn from long term use of beta-blockers. The authors report an increase in heart rate, aggravation of angina, palpitations and mental symptoms. The catecholamine levels did not vary from the control group but 8 of 32 patients who had been on beta-blockers had to be restarted one month later. Beta-adrenoceptor hypersensitivity was postulated for 2-3 weeks as the cause of the rebound phenomenon. (Hjemdahl, P., Olsson, G.: *Acta Med Scand* 212:43-7 Feb 1983)

Fourteen patients with history of chronic alcoholism had electrophysiologic evaluations after provocation with 90cc of 80 proof ethanol by injection. Eight of these patients exhibited arrhythmias, and one patient presented a Mobitz II arterioventricular block. Ethanol thus appears to be a significant arrhythmic agent in chronic alcohol users. (Greenspan, A.J., Schaal, S.F.: *Ann Intern Med* 98:135-9 Feb. 1983)

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Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

DECEMBER

Clinical Medicine

Computers and Clinicol Medicine
For: MD's. Symposium, Dec. 1, 1:00 p.m., Sparta. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. limit:** none. **Credit:** Cotegory 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Gerontolagy

Pragmotic Clinicol Gerontology
For: MD's. Symposium, Dec. 7, Chicago. **Sponsor:** IMMG-Worren Barr Pavilion of Illinois Masonic Medical Center, 66 W. Oak St., Chicago 60626. **Reg. deodline:** Nov. 1. **Fee:** none. **Reg. limit:** 100. **Credit:** Category 1, 8 hours; AAFP Prescribed, 8 hours. **Contact:** Bertram Moss, MD. **Phone.** 312/337-5400 × 268.

Heart Disease

Diognasis & Monogement of Myocordial Infarction
For: MD's. Symposium, Dec. 9-10, Madison, WI. **Sponsor:** U of Wisconsin—Extension, CME, 465b WARF Bldg., 610 Walnut St., Modison, WI 53705. **Fee:** $160. **Reg. limit:** none. **Credit:** Category 1, 10 hours; AAFP Prescribed, 9½, applied for: AOA, 10 hours. **Contact:** Sarah Aslokson. **Phone:** 608/263-2856.

Medical Education

Applicotions of Problem-Based Learning in Pre-Clinical Disciplines
For: MD's. Workshop, Dec. 5-8, Carbondale. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springifeld 62708. **Fee:** yes. **Reg. limit:** yes. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Medicine Grand Raunds
For: MD's. Lecture, Wednesdays, 11:00 a.m. **Sponsor:** Dept. of Medicine, UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Cotegory 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Medicine

Environmentol Medicine
For: Internists, GP's, FP's. Lecture, Dec. 5-9, Chicogo. **Speakers:** Stephen Greenberg, PhD; Emerson Day, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $370. **Reg. limit:** 90. **Credit:** Cotegory 1, 30 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Neurology

Clinical Neuraimmunology
For: Neurologists, Psychiatrists, Immunologists. Course, Dec. 7-9, Chicogo. **Sponsor:** University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. **Fee:** NA. **Reg. limit:** none. **Credit:** Category 1, 18 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Neurology

Neurology for the Non-Neurologist
For: Internists, FP's, GP's, Psychiatrists, Rehab. Medicine. Course Review, Dec. 7-9, Chicogo. **Sponsor:** Rush University, CME, 600 S. Paulina, Chicogo 60612. **Fee:** $350. **Reg. limit:** none. **Credit:** Category 1, 20 hours; AAFP opplied for. **Contact:** Barbaro Trejo. **Phone:** 312/942-7095.

Ob-Gyn

Problem Solving in Gynecologic Endocrinology ond Infertility
For: MD's. Course, Dec. 9-10, Chicago. **Sponsor:** University of Chicago, CME, 950 E. 59th St., Box 139, Chicago 60637. **Fee:** $195. **Reg. limit:** none. **Credit:** Category 1, 11 hours; ACOG, 11 cognates. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Ob/Gyn

Outpotient Gynecology
For: GP's, FP's. Seminar, Dec. 3, o.m., Urbana. Sponsor: Carle Foundation Hospital, 602 W. University, Urbana 61801. **Reg. deodline:** 11/25. **Fee:** $35. **Credit:** Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Deborah Rugg. **Phone:** 217/337-3022.

Pathology

Madren Serology Labarotory, Selected Topics and Application
For: Pathologists. Lecture, Dec. 12, 7:00 p.m., Chicago. **Sponsor:** Chicago Pathology Society, c/o Morshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Reg. deodline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours.

Radiology

Visiting Fellowships in Diognostic Rodiology
For: Radiologists. Course, one or two weeks (year-round), Chicago. **Sponsor:** University of Chicogo, 950 E. 59th St., Box 139, Chicogo 60637. **Fee:** $450 per week. **Credit:** Category 1, 40 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Tharacic Surgery

Specialty Review in Thorocic Surgery
For: Surgeons. Lecture, Dec. 5-10, Chicago. **Speoker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. limit:** 20. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

JANUARY

Internal Medicine

Lake County Medical/Surgicol/Psychiotry Seminar
For: MD's. Seminar, Jan. 25, 8:00 a.m., Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Woukegan 60085. **Fee:** $10. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Cantact:** Dr. R. M. Adelmon. **Phone:** 312/578-2555.

Internal Medicine

Medical Seminor-ot-Sea
For: MD's. Seminar, Jan. 8-19, Caribbean Sea. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 48 hours. **Cantact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Results of Recent Advonces in Medicine
For: Internists, Pediatricians, FP's. Course, Jon. 15-18, Telemark Lodge, Cable, Wisconsin. **Sponsor:** U Of WI—Extension, CME, 454 WARF Bldg., 610 Walnut St., Modison, WI 53705. **Fee:** $245. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours. **Phone:** 608/263-2854.

Sparts Medicine

Hawkeye Sparts Medicine Symposium
For: MD's. Symposium, Jon. 5-7, Iowo City, Iowa. **Sponsor:** U of Iowa, College of Medicine, CME, 285 Med Labs, Iowa City, IA 52242. **Reg. deadline:** none. **Fee:** $225. **Reg. limit:** none. **Credit:** Category 1, 17.5 hours; AAFP Prescribed, 17.5 hours. **Phone:** 319/353-5763.

Surgery

Specialty Review in Generol Surgery, Port II
For: generol and specializing surgeons. **Lecture,** Jan 23-Feb. 2, Chicago. **Speoker:** Robert Baker, MD. **Spansor:** Cook County Graduote School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Credit:** Category 1, 100 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

FEBRUARY

Family Medicine

Medical Seminar-at-Sea
For: MD's. Seminar, Feb. 18-Mar. 5, Ponomo Conol. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 66 hours. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Gastraenterology

Gastroenterology Symposium
For: MD's. Symposium, Feb. 3, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Medical Educatian

Evaluation of Clinical Competence
For: MD's. Workshop, Feb. 9-10, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** yes. **Credit:** Category 1. **Contact:** Lorroine Stephenson. **Phone:** 217/782-7711.

Family Medicine

Advances in Family Practice
For: FP's, GP's. Lecture, Feb. 13-17, Chicogo. **Speakers:** Horry Morchmont-Robinson, MD; Sheldon S. Woldstein, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $390. **Reg. limit:** 150. **Credit:** 35 hours, Categery 1. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Neuralagy

Basic Science of Neurology
For: Neurologists, Psychiotrists. Lecture, Feb. 20-24, Chicogo. **Speaker:** John Hughes, MD, PhD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $450. **Reg. limit:** 90. **Credit:** Categery 1, 42 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Surgery

Specialty Review in Pediatric Surgery
For: Surgeons. Lecture, Feb. 6-9, Chicogo. **Speaker:** Hernon Reyes, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $390. **Credit:** Categery 1, 36 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Surgery

Review Course in Neurological Surgery
For: Neurosurgeons, Neurologists. Lecture, Feb. 3-12, Chicogo. **Speakers:** Leonord Kronzler, MD; Sean Mullon, DSc. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $675. **Reg. limit:** none. **Credit:** Categery 1, 101 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

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The ISMS Committee on Accreditation has approved the CME programs of the following institutions:

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Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

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President's Page



Leadership Conference

On a typical Fall day in central Illinois, as the successful "Fighting Illini" clinched their Rose Bowl bid, 250 persons gathered at the Holiday Inn in Decatur to participate in the Illinois State Medical Society Leadership Conference. I prevailed upon the Editor to await my message so that I may introduce the results of the successful November 12 and 13 meeting in this issue of the *Illinois Medical Journal.*

Let me initially reflect the pride I experienced as I viewed the full assembly in the morning of the opening session and greeted the attending physicians, their spouses, and medical society executives.

The opening session was keynoted by Jeff Goldsmith, Ph.D., author of the book "Can Hospitals Survive?" In his usual articulate and precise fashion, he documented the pervasive overtones of the economics of the present health care delivery system: how they will affect the quality of care, the peer review system, the physician payment system and, last but not least, the professional liability picture.

This was followed by an informative session in which Dr. Fred White, past president of ISMS, and Mr. John Simon, our attorney, outlined a potential legislative effort for the forthcoming year. The thrust of this effort has been agreed upon by the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the Board of Trustees of ISMS. The speakers explained that, if sufficient membership support is evidenced by the current membership survey poll on the topic, we will seek tort reform which, we hope, will affect liability premiums in a significant manner. We will be seeking your support in this legislative effort.

The evening and next morning dealt with legislative matters. U.S. Representative Edward Madigan (R-15th) addressed the dinner assembly and emphasized the importance of national legislative efforts during a time when the elected administration is moving to make changes in many of the programs that affect the patients we care for and our colleagues in the profession. Alfred Balitzer, Ph.D, author of "A Nation of Associations," U.S. Representative Richard Durbin (D-20th) and Illinois State Representative Judy Baar Topinka (R-43rd) concluded the Sunday morning general session with acknowledged importance of associations and their role in the education and election of a favorable, informed legislative body.

This is a prelude to the January issue of the *IMJ* where details of the Leadership Conference will be published.

Keep alert to the future educational efforts of your state society as the pressures to change medical care delivery mount. ◀

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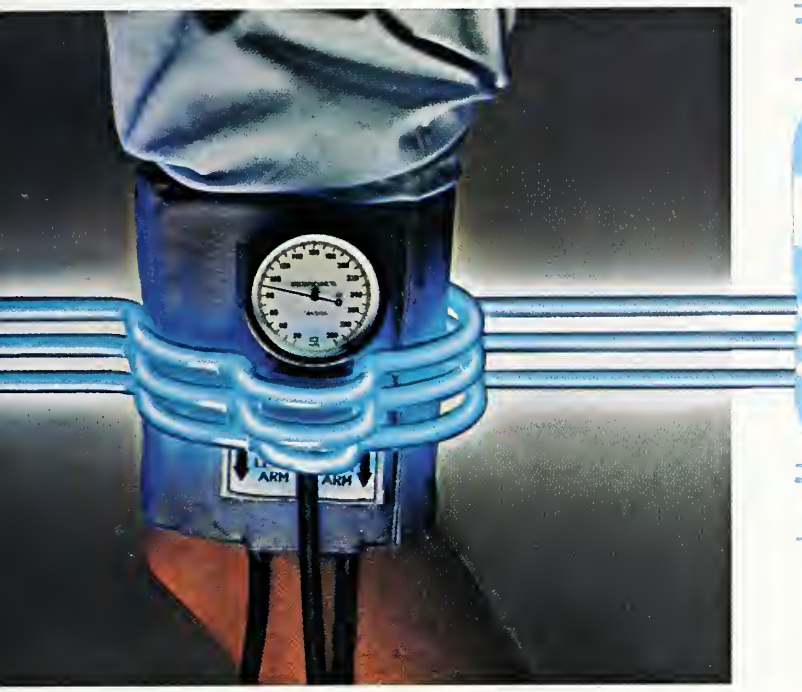
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The one to count on for HYPERTENSION, ANGINA and prevention of MIGRAINE.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

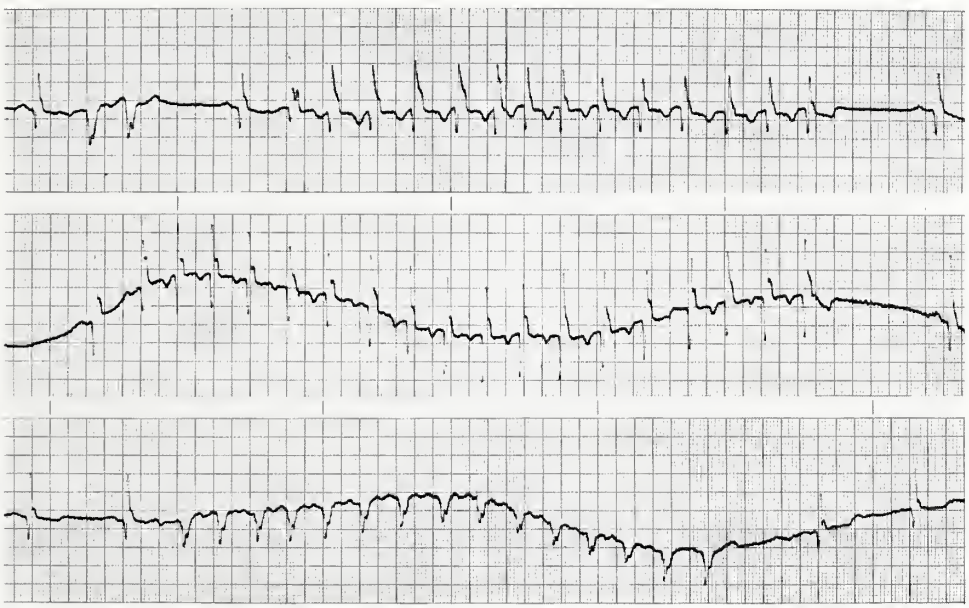
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New York, N.Y. 10017

EKG of the Month

CONTRIBUTING EDITORS: JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D., JOHN R. TOBIN, M.S., M.D., ROLF M. GUNNAR, M.S., M.D., AND PATRICK J. SCANLON, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This patient is a 70 year old man whose history included an inferior wall myocardial infarction 11 years ago. One year later he developed angina and a coronary angiogram showed severe triple vessel coronary disease. He underwent triple vessel aorta coronary bypass surgery and was asymptomatic for the next ten years. He now complains of intermittent palpitations and episodes of fatigue. His fatigue has prevented him from playing golf. He denies any chest pains or dyspnea and sleeps well. His physical examination, which showed a blood pressure of 140/88mmHg and a well healed median sternotomy scar, was otherwise unremarkable. A chest X-ray showed a normal heart size and signs of a thoracotomy. A thallium exercise ECG revealed only non-reversible ischemia on the posterolateral wall compatible with his old myocardial infarction. No arrhythmias were seen. A 24 hour ambulatory ECG was ordered. At the time when these ECG strips were recorded, the patient complained of palpitations.

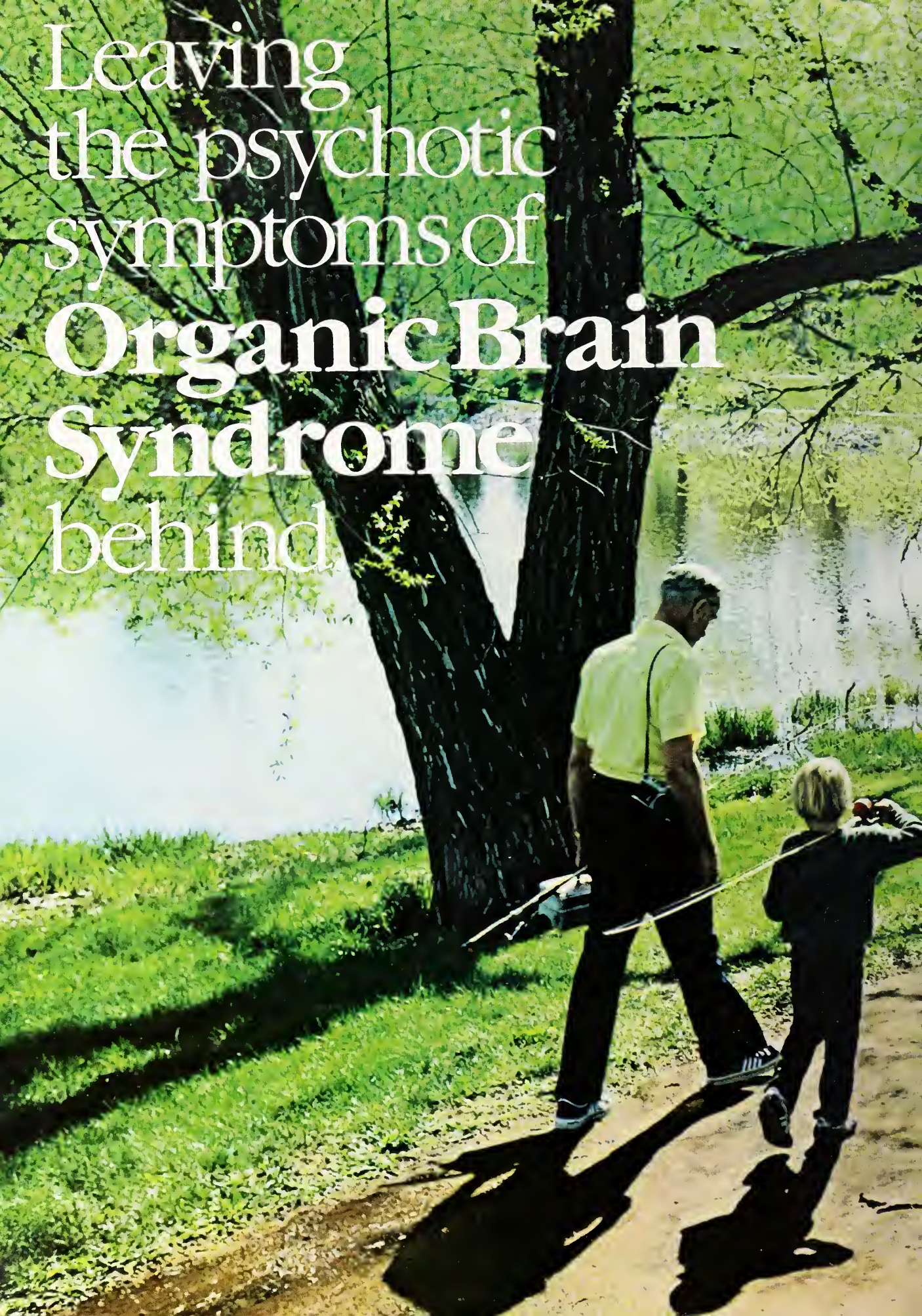


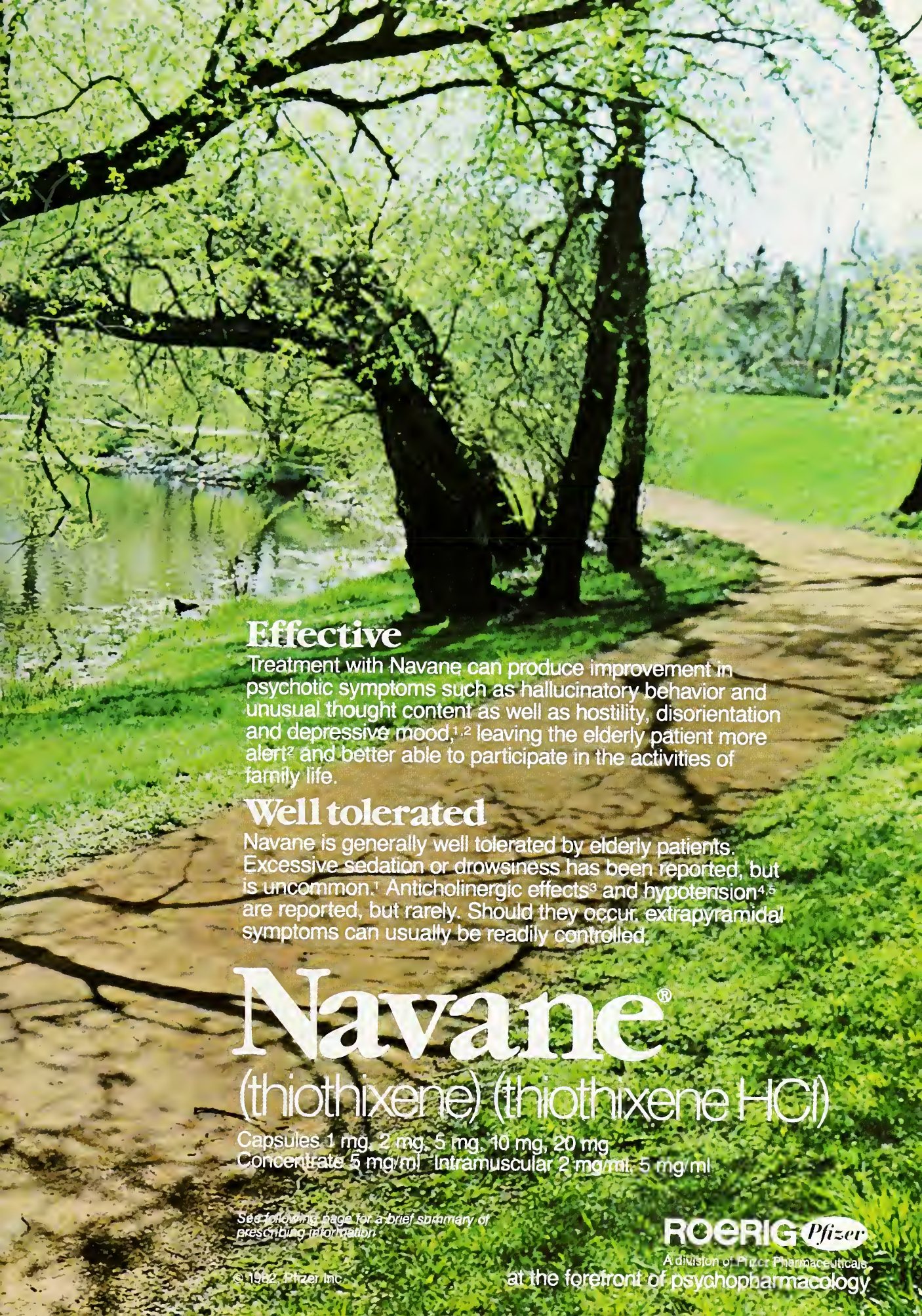
Questions:

1. **The ECG strips from the 24 hour ambulatory ECG show:**
   a. Intermittent ventricular tachycardia.
   b. Polymorphous ventricular tachycardia.
   c. Paroxysmal supraventricular tachycardia with occasional aberrant intraventricular conduction.
   d. The bradycardia-tachycardia variant of the sick sinus node syndrome.

2. **Which of the following should be included in the plan of management?**
   a. Electrophysiologic pacing study.
   b. Digoxin.
   c. Lidocaine intravenously.
   d. Procainamide orally.
   e. All of the above.

(Continued on page 513)


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

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at the forefront of psychopharmacology

Navane®
(thiothixene) (thiothixene HCl)

References 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16. 1972. 2. Katz MM, Util TM. Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974 3. Ketai R. Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml
Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.
Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy Therefore, the patient should be cautioned accordingly

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs

Undue exposure to sunlight should be avoided Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis, the available evidence is considered too limited to be conclusive at this time

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury Intramuscular injections should not be made into the lower and mid-thirds of the upper arm As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: *Note*: Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines The clinical significance of these changes is not known

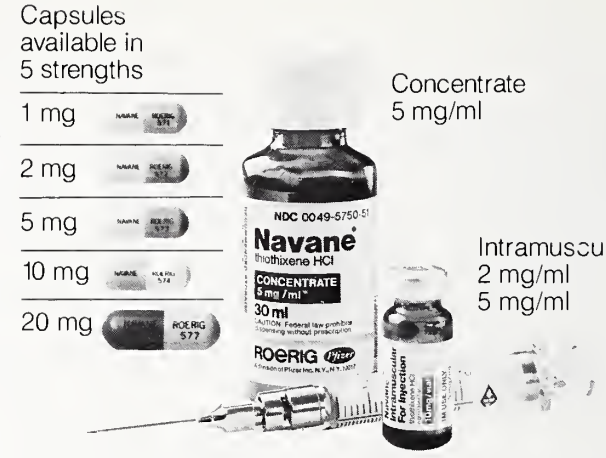
CNS effects. Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene) Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported Management of these extrapyramidal symptoms depends upon the type and severity Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects. As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia

Allergic reactions. Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders. Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules. Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily It indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma

Treatment. Essentially is symptomatic and supportive For Navane oral, early gastric lavage is helpful For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I V fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

Obituaries

**Anthony, Benjamin W., Chicago, died October 30, 1983 at the age of 81. Dr. Anthony was a 1928 graduate of Rush Medical College.

**Bornemeier, Walter C., Saratoga, California, died November 4, 1983 at the age of 82. A 1929 graduate of Northwestern University Medical School, Dr. Bornemeier was a general surgeon who practiced in Chicago for 42 years.

An ISMS councilor (trustee) 1949-1950, Dr. Bornemeier was the speaker of the ISMS House of Delegates, 1960-64. Also active at the county level, he served as president of the Chicago Medical Society, 1953-54, chairman of the CMS Council, 1952-53 and secretary, 1951-52.

Dr. Bornemeier served as the 1970-71 president of the American Medical Association. A member of the ISMS delegation to the AMA, 1954-1969 (and an honorary member until his death) Dr. Bornemeier was the secretary of the ISMS delegation 1957-58 and chairman, 1959-60. He served as vice speaker of the AMA House of Delegates, 1956-66 and speaker 1967-68.

Dr. Bornemeier is survived by his wife, Mabel; two daughters, Lois M. Kettel and Beatrice A. Fiedler; a son, Walter II; and four sisters.

*Bush, Thadd F., Wilmette, died October 31, 1983 at the age of 69. Dr. Bush was a 1940 graduate of the Loyola University Stritch School of Medicine, Maywood.

*Freiband, Benjamin M., Rock Island, died October 25, 1983 at the age of 77. Dr. Freiband was a 1939 graduate of Medical School American University of Beirut, Lebanon.

**Gasteyer, Theodore H., Oak Lawn, died November 1, 1983 at the age of 82. Dr. Gasteyer was a 1931 graduate of Rush Medical College, Chicago.

*Gazda, Mace, Chicago, died September 27, 1983 at the age of 76. Dr. Gazda was a 1937 graduate of Rush Medical College, Chicago.

Goddard Robert L., Wheaton, died October 2, 1983 at the age of 65.

**Heumann, Johanna N., Chicago, died October 6, 1983 at the age of 89. Dr. Heumann was a 1919 graduate of Rush Medical College.

*Hootnick, Jacques I., Chicago, died October 27, 1983 at the age of 77. Dr. Hootnick was a 1934 graduate of the University of Health Sciences, Chicago Medical School.

*Jack, Nelson Briggs, Decatur, died October 7, 1983 at the age of 72. Dr. Jack was a 1938 graduate of Northwestern University Medical School, Chicago.

**Lenit, Harold Walter, Chicago, died October 14, 1983 at the age of 85. Dr. Lenit was a 1924 graduate of the University of Illinois College of Medicine, Chicago.

*Newman, Helen Cook, Chicago, died September 28, 1983 at the age of 76. Dr. Newman was a 1935 graduate of George Washington University School of Medicine, Washington.

**Paulauskis, Stanley, Quincy, died October 14, 1983 at the age of 78. Dr. Paulauskis was a 1933 graduate of Vytauta Didziojo Universiteto Medicinos Fakelyo, Kaunas, Lithuania.

Rabinowitz, Murray, Chicago, died October 18, 1983 at the age of 55.

**Rubenstein, Hyman I., Chicago, died October 27, 1983 at the age of 83. Dr. Rubenstein was a 1926 graduate of the Loyola University Stritch School of Medicine, Maywood.

**Rylander, Carl M., Quincy, died September 30, 1983 at the age of 85. Dr. Rylander was a 1922 graduate of Washington University School of Medicine, St. Louis, Missouri.

**Sodaro, Joseph C., Lake Worth, Florida, died October 20, 1983 at the age of 87. Dr. Sodaro was a 1924 graduate of the University of Illinois College of Medicine, Chicago.

*Vertuno, John W., Melrose Park, died October 27, 1983 at the age of 79. Dr. Vertuno was a 1934 graduate of the Loyola University Stritch School of Medicine, Maywood.

**ISMS member.*
***Member of the Fifty Year Club.*

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

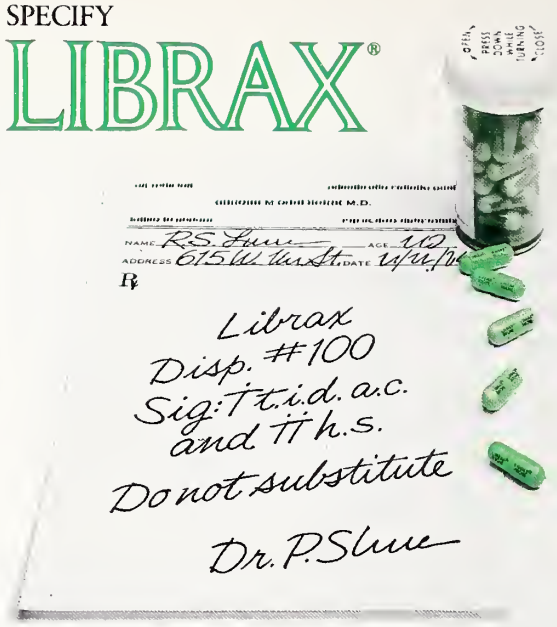
Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

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Please consult complete prescribing information, a summary of which follows:

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/ Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.
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As with all anticholinergics, inhibition of lactation may occur.
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.
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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

January 3	Illinois Interagency Council on Smoking & Disease	Chicago
January 3	Hinsdale Sanitarium & Hospital & ACS	Hinsdale
January 10	Northwestern Memorial Hospital	Chicago
January 17	Carle Clinic Assn & ACS	Urbana
February 1	Illinois Interagency Council on Smoking & Disease	Chicago
February 6	Hinsdale Sanitarium & Hospital & ACS	Hinsdale
March 5	Hinsdale Sanitarium & Hospital & ACS	Hinsdale
March 6	Northwestern Memorial Hospital	Chicago
March 6	Illinois Interagency Council on Smoking & Disease	Chicago
April 1	Hinsdale Sanitarium & Hospital & ACS	Hinsdale
April 3	Illinois Interagency Council on Smoking & Disease	Chicago
May 1	Northwestern Memorial Hospital	Chicago
May 1	Illinois Interagency Council on Smoking & Disease	Chicago
May 7	Hinsdale Sanitarium & Hospital & ACS	Hinsdale
June 5	Illinois Interagency Council on Smoking & Disease	Chicago

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria. 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"My daily routine consisted of sitting in my chair trying to stay alive."

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"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

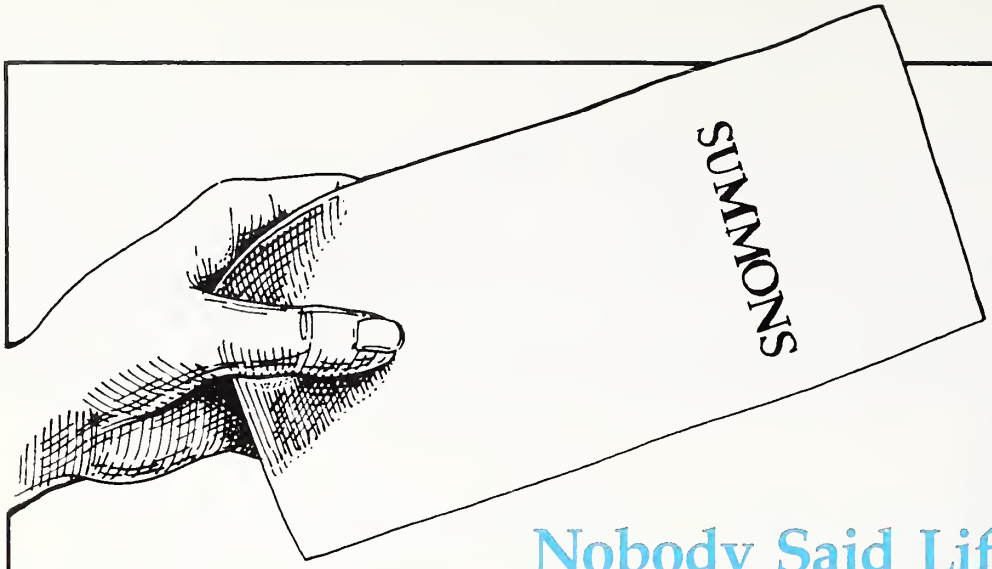


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PROCARDIA®
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ocardia is indicated for the management of:
Confirmed vasospastic angina.
Angina where the clinical presentation suggests a possible sospastic component.
Chronic stable angina without evidence of vasospasm in atients who remain symptomatic despite adequate doses of eta blockers and/or nitrates or who cannot tolerate these gents. In chronic stable angina (effort-associated angina) ROCARDIA has been effective in controlled trials of up to ght weeks' duration in reducing angina frequency and creasing exercise tolerance, but confirmation of sustained fectiveness and evaluation of long-term safety in these atients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*



Nobody Said Life Was Fair!

Life hasn't been fair to physicians lately. Skyrocketing malpractice claims and whopping damage awards have caused premiums for malpractice insurance to soar.

Like other insurers, the Illinois State Medical Inter-Insurance Exchange has not been immune to rising professional liability costs, and premiums have had to be increased accordingly. At the same time, the Exchange — through its physician ownership — is constantly striving to maintain reasonable and equitable insurance premiums by making appropriate changes in its underwriting program.

That's why the Exchange has undertaken the most comprehensive restructuring of its professional liability program since 1977. Many revisions have been made for the 1983-84 program year — including creation of a lower risk classification and a third rating territory which will provide some physicians with premium reductions.

Illinois counties that have favorable loss experience have been assigned lower rates. Based on loss experience data pertaining to specialty and procedures performed, the Exchange was able to further refine its underwriting program to more accurately reflect practice exposures.

The Exchange is dedicated to maintaining a viable, responsive and fiscally sound insurance program for the long-term benefit of its members. We will continue to make revisions in our professional liability program as evidence of our commitment to provide Illinois physicians with the best professional liability protection available in the most equitable manner possible.

Physician Ownership Makes a Difference!

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Special Articles

Illinois Rescinds Mandatory CME Law

On September 24, Governor James Thompson signed into law Senate Bill 1191 (P.A. 83-863) rescinding the 1978 mandatory CME requirements. Effective January 1, 1984, Illinois physicians are no longer required to document the fact that they have completed 100 hours of mandatory CME.

Mandatory CME: A State and Nation-Wide Concern

In recent years, the national attitude toward mandatory CME has been one of hesitation and reanalysis. While 25 states have legislation for mandatory CME on the books, only 19 have actually implemented it. Until September, 1982, 20 states reported mandatory CME laws in effect but Colorado recently rescinded its mandatory CME provision.

Considerable concern about the efficacy of mandatory CME had been reported in Illinois. Recently, an informal poll conducted by the ISMS division of membership and marketing services, showed that physician members from Cook, DuPage, Winnebago, Peoria and Rock Island counties overwhelmingly preferred voluntary CME to mandated learning (159 in favor of voluntary—57 in favor of mandatory). At the 1982 ISMS annual meeting a resolution approved by the House of Delegates pointed out many negative aspects of mandatory CME (*e.g.*, it is not a guarantee of physician competence, it has an arbitrary system of record-keeping, it violates basic principles of adult learning). The five years that Illinois has had mandatory CME as a requirement for physician relicensure have produced no tangible evidence that the law has significantly improved physician performance. Physicians have traditionally participated in continuing medical education programs as a part of their professional growth and development.

Clarification by the Department of Registration and Education

A recent statment by the Department of Registration and Education (DRE), outlined some ramifications of the new law which apply to Illinois physicians with active or inactive licenses.

> "Although P.A. 83-863 repeals CME requirements prospectively, its effective date as a law is January 1, 1984. Until that date, both Section 5.1 and the Rules of the Department which implement it (68 Ill.Adm.Code Part 280, par. 280.100) remain in full force and effect. Also remaining in full force and effect are DRE's powers to extend the time during which CME requirements may be met. It is therefore DRE's position that:
>
> "1. Physicians who have been granted presently effective extensions of time for the completion of CME requirements, and physicians who make such requests between now and January 1, 1984, will be extended to January 1, 1984, at which time physicians practicing with extensions of time will be eligible to renew or reinstate their licenses, assuming all other requirements for licensure have been met. All appropriate reinstatement fees will be required.
> "2. Physicians whose licenses have not been renewed for failure to complete CME requirements, and who have not requested and received extensions of time to complete CME requirements will be eligible on January 1, 1984, to renew their licenses, assuming all other requirements for licensure have been met. Payment of the appropriate reinstatement or restoration fee will be required.
> "3. Reinstatement or restoration fees will be computed according to the provisions of Section 14 of the Medical Practice Act (Ill.Rev.Stat. 1981, Ch.111, par. 4429)."

This means that after January 1, 1984, there will be no need for Illinois physicians to report the past two years' CME hours to become licensed for the next two year cycle due to begin July 1984.

Ongoing Need for Quality CME Programs

The action in Springfield can be seen as a definite

vote of confidence in physicians. Clearly, legislators understand that physicians consider continuing education to be a basic responsibility of every licensed practitioner. Accreditation of CME programs in Illinois existed ten years before the mandatory law was enacted. Illinois accreditation procedures and principles have long been models for other states. These facts are a strong indication that the medical profession was concerned about quality CME long before the state attempted to mandate professional learning.

Evidence of participation in continuing medical education may still be needed for hospital staff membership credentialing, Board certification and recertification, specialty society membership and participation in the AMA Physician Recognition Award. The Illinois State Medical Society will continue to support accreditation of CME programs and the development of quality continuing medical education activities. By returning voluntary CME to the physicians of Illinois, the legislature and the Governor have given medicine an opportunity to demonstrate that the profession recognizes that life-long learning is an essential component of quality and excellence in medicine.

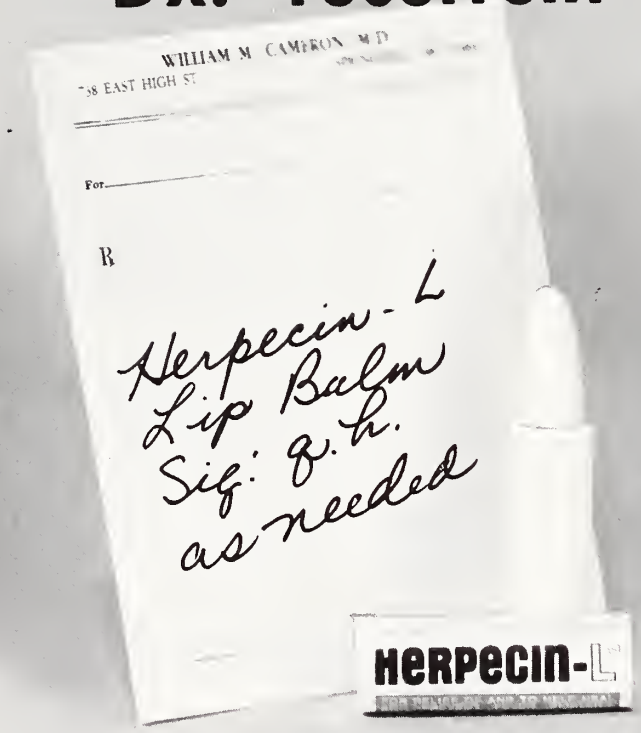
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IMJ
Illinois Medical Journal
Volume 164, No. 6, December 1983

Analysis of 220 Aneurysms

Medical and Surgical Treatment Of Ruptured and Unruptured Intracranial Aneurysms

By Jose L. Salazar, M.D./Chicago

Subarachnoid hemorrhage (SAH) due to ruptured aneurysms is a major neurologic catastrophe. Symptoms may appear at any time between early life to old age, but are most common in persons between 50 and 60 years of age. SAH is a clinical syndrome which is not always recognized.[1-3]

SAH consists of sudden onset, severe, generalized headache. This headache can sometimes be associated with strenuous exercise but it may also appear at rest. It is usually associated with neck pain and stiffness due to blood in the cerebral spinal fluid with irritation of the meninges and may produce positive Kernig and Brudzinski's signs. The clinical findings may include early unconsciousness suggesting bleeding from an anterior communicating or basilar aneurysm, hemiparesis and hemispheric symptoms due to a middle cerebral or internal carotid artery aneurysm, or third nerve palsy due to a posterior communicating artery aneurysm. In some cases, the initial headache is followed by deepening degree of confusion, fever, photophobia, and retinal and subhyloid hemorrhages. Complications such as vasospasm, hemispheric symptoms of "stroke," hydrocephalus, rebleeding and persistent coma are not unusual.

The early diagnosis by recognizing the clinical picture and the confirmatory tests such as L.P., C.T. of the brain, and angiography may decrease mortality by initiating prompt medical and then surgical treatment.

Incidence and Natural History

It is difficult to know the exact incidence of ruptured aneurysm because many patients die before receiving medical attention. Post mortem studies are not performed in many cases and other cases are treated as hypertensive hemorrhages or strokes. When a post mortem study *is* done, the finding of an intracranial aneurysm is directly related to the care given to pathological search. In a retrospective study of 13,185 autopsies reported by McCormick and Nofzinger,[4] 153 patients (1.2%) were discovered to have aneurysms. Stebbens[5] reported a 5.6% incidence. In a later prospective and consecutive autopsy series of 1,587 patients, he found 125 aneurysms for an incidence of 7.8%.[6]

Fifty to eighty percent of all intracranial hemorrhages are due to ruptured aneurysms.[3] The natural history of cerebral aneurysms after rupture is well known. Many papers[7-9] have appeared dealing with the prognosis of unoperated ruptured aneurysms

Jose L. Salazar, M.D., is a board certified neurological surgeon affiliated with the University of Illinois Medical Center, Illinois Masonic Medical Center and Northwest Community Hospital in Chicago. Dr. Salazar is an associate professor of neurological surgery and director of the microsurgical laboratory at the UI Medical Center. He is a fellow of the American College of Surgeons and cites particular interest in vascular and microneurosurgery.

Table 1

Patients					
Grades	A	I	II	III	IV
At admission	40	28	38	42	7
At surgery	40	48	40	27	0

A = asymptomatic patients I-IV = Boterell's classification

Table 2
Distribution of 155 patients by sex and age

Age	0-10	11-20	21-30	31-40	41-50	51-60	61-70	Total
M	0	1	6	16	9	16	3	51
F	0	2	7	22	25	32	16	104

with a mortality rate ranging from 25% to 45% during the first six weeks after initial bleeding. The Cooperative Study found a 10-15% mortality rate among patients admitted to the hospital following the first episode of bleeding from a single aneurysm.[10] Mortality figures for the second rupture were 41-46%[8] and rebleeding was found to be more common during the first two weeks.

Jane[2] concluded that approximately 66% of patients die as a result of the first bleeding episode and many do not receive medical intervention on time. Most survivors with a diagnosis of aneurysm are kept at complete bed rest. Surgical treatment, if performed, is usually delayed for a period of more than two weeks.

The rebleeding rate after six months, if the patient survives, is 3-4% a year and the mortality associated with late rebleeding is about 67%.[11]

All of the above results should be considered in appraising any specific treatment for subarachnoid hemorrhage (SAH) due to aneurysms.

Mortality after surgery has been consistently lower than the above, and results are further improved with the operative microscope.[12,13] Although cooperative studies are useful for determining the incidence of aneurysms, complications of bleeding and associated factors in the patients with subarachnoid hemorrhage, they are not accurate with regard to surgical treatment since they lump together the results of experienced and nonexperienced surgeons.

This report deals with 155 patients admitted and operated on at two Chicago hospitals during the period 1970-1981. Patients with a total of 220 intracranial aneurysms were admitted and treated *consecutively* at these two institutions by the author. On admission, each patient was graded by the classification of Botterell:[14]

Grade I: patient who is conscious with or without signs of blood in the subarachnoid space.

Grade II: drowsy patient without significant neurologic deficit.

Grade III: drowsy patient with a neurologic deficit and probably an intracerebral clot.

Grade IV: includes patients with a major neurological deficit and deteriorating because of large intracerebral clots or older patients with less severe neurological deficit, but with pre-existing degenerative cerebrovascular disease.

Grade V: represents a moribund or near moribund patient with failing vital centers and extensor rigidity.

Angiography was performed as soon as the patient's condition was stable for Grades I and II and was done after five days for higher grades. If a hematoma was suspected and the patient was deteriorating, angiography was done earlier. Patients entering the hospital in Grade IV or V usually had no angiograms. When they became available, CT scans were done as emergency procedures to rule out intracranial hematoma. When surgery was not considered feasible, angiography was not performed.

Three vessel study angiogram was usually done by percutaneous route. Four vessel angiogram has been done more frequently in the last year. All patients with SAH were admitted to the intensive care unit and treated according to protocol. This included sedation, a dark quiet room with no visitors except family, head elevated 30° to 45°, stool softeners, elastic stockings and other supportive measures as needed. A markedly elevated systemic blood pressure, (*i.e.*, over 160mmHg systolic) was gradually reduced with a diuretic or a combination of drugs including chlorpromazine, hydralazine hydrochloride, hydrochlorothiazide, or intravenous sodium nitroprusside. Severely hypertensive patients were usually in the higher IV or V Botterell grades and required larger doses of sodium nitroprusside. Patients in low grade (I-II) needed only mild sedation, but there was no vigorous attempt to lower the blood pressure to normal. All patients in Grades II or higher received dexamethasone at admission 4-6mg. every four hours initially, and all patients with SAH were given epsilon-aminocaproic acid, 0.3 to 0.5gm/kg body weight/day intravenously. The timing of the operation, between the onset of SAH and the time of surgery, varied according to grades. For patients in Grade I, it depended on their medical condition and

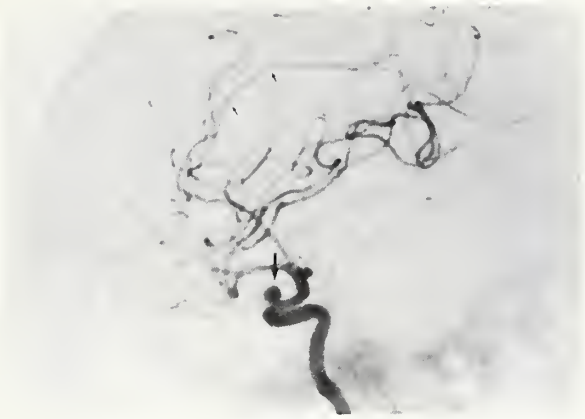


Figure 1
Transfemoral left carotid angiogram, lateral view shows a 5mm aneurysm in the left internal carotid just above the ophthalmic pointing superiorly (large arrow) and bowing of the pericallosal artery due to hydrocephalus (small arrow).



Figure 2
Transfemoral left vertebral angiogram, lateral view shows a bilobe 4mm aneurysm in the left PICA (posterior inferior cerebellar artery).

neurologic status, including headache, stiff neck, control of blood pressure, and spinal fluid pressure. The majority of patients with SAH admitted in the first three days had elevated systemic blood pressure usually associated with the increased intracranial pressure due to the SAH. Blood pressure gradually came down to normal within 3-4 days. In hypertensive patients, blood pressure remained high and needed specific therapy despite improving condition. The average time from bleeding to time of surgery was 9.4 days in Grade I patients after SAH. Grade II patients had an average preoperative delay of 9.9 days. Grade III patients had an average preoperative interval of 16 days. Grade IV patients had the longest waiting period, an average 27.5 day delay, while we attempted to improve their conditions through medical treatment. Patients in Grade I had surgery as soon as possible, but because of the referral pattern, many of these patients in Grade I were admitted at the end of the first week or later. Most patients improved from the time of admission to time of surgery. (See Table 1)

Fronto-temporal craniotomy, usually the right side, (nondominant hemisphere) was used for the majority of the aneurysms of the anterior circle of Willis and for many of the basilar artery aneurysms. Other approaches were used as needed. All aneurysms were dissected under magnification using the operative microscope with isolation of perforating vessels and clear identification of the parent vessels and the neck of the aneurysm. With this technique even aneurysms which seem to be unclippable are almost always found to have a neck which can be clipped or ligated. Arterial hypotension was induced during surgery to reduce problems with rupture during manipulation. Giant aneurysms usually require more hypotension. Often ligation and multiple clips are needed for proper control. All patients were encouraged to have post-op angiograms. These were done unless the aneurysmal sac was opened or resected during surgery or there was some unusual danger in doing the procedure. We believe that once the aneurysm is evacuated by draining its contents and opening the sac with the use of an adhesive glue following the clipping of the aneurysms there is no real need for post-operative angiogram. It has become routine to use ethyl-cyanoacrylate ("Aron Alpha") to cement the clip in place to prevent its slipping and reinforce weak areas which may later on develop in aneurysms.

Classification

Three categories were used for clinical results. *Excellent:* Active, normal mentation, no neurologic deficit. *Good:* Moderately restricted activity, nor-

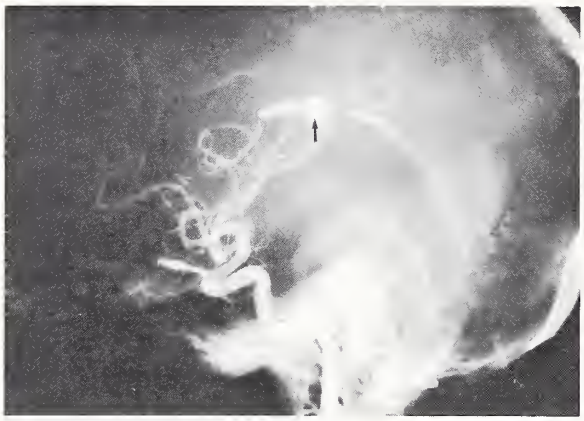


Figure 3
Post operative left carotid angiogram, lateral view, shows the obliteration of the carotid aneurysm by a metal clip (horizontal arrows) and a Denver shunt into the lateral ventricle (vertical arrow).



Figure 4
Post operative left vertebral artery angiogram, AP view shows the metal clip obliterating the left PICA aneurysm (horizontal arrow) and the right sided shunt tube (vertical arrow).

mal mentation, moderate neurologic deficit (hemiparesis). *Poor:* Marked restricted activity, mental changes, a disabling neurologic deficit.

"Surgical mortality" implies death in hospital or within one month from the time the patient was discharged from the hospital following surgery.

Case Report

This is a 63-year-old white male admitted to the emergency room when he suddenly complained of headache and collapsed while at work trying to pick up a heavy piece of equipment. On admission, he was awake and complaining of severe headache, stiff neck and a right Babinski sign. BP was 150/100, but upon initial admission had been 220/120. Spinal tap showed grossly bloody fluid with pressure of 250mm of water. The patient was lethargic, moving all his extremities fairly well. He had a slow, regular respiratory rate with bilateral lateral rectus palsy without papilledema or hemorrhage.

Five days later, the patient underwent four vessel transfemoral arteriogram. A left internal carotid artery aneurysm pointing superiorly and measuring about 5mm in diameter was evident. Another aneurysm was found on the left PICA (posterior inferior cerebellar artery) measuring 4mm in diameter (Figures 1, 2).

Because the aneurysm on the left PICA was bilobular, we felt that it was the site of the bleeding. After the patient's condition improved, (two weeks after the arteriogram) a posterior fossa craniectomy, C1 laminectomy and clipping of PICA aneurysm were done. Postoperatively, the patient developed headache and lethargy. Investigation with CT scan showed progressive hydrocephalus treated with a right ventriculo-peritoneal shunt one week after surgery. Postoperatively, the headache subsided and his state of alertness improved to the point that, three weeks later, a left fronto-temporal craniotomy, clipping and coating of the left internal carotid aneurysm were performed. The patient recovered uneventfully and was discharged from the hospital two months after first admission, alert, able to walk with assistance, and physically improved. Postoperative angiograms showed obliteration of the aneurysms by metal clips (Figures 3, 4). The patient was re-evaluated three months after discharge. He was alert, and although he still complained of intermittent ringing in the ears, his mental condition was greatly improved and neurologic examination was essentially normal without gross pathologic reflexes. The patient continued on phenytoin 100mg. t.i.d. and has since done well, followed by his family physician.

Clinical Results

A total 155 patients with 220 aneurysms were surgically treated. This includes 177 (53%) ruptured aneurysms associated with SAH. Also in this group there were nine patients with nine internal carotid artery aneurysms associated with unilateral III nerve palsy without obvious SAH, three patients with three aneurysms with III nerve palsy and SAH, and one patient with one basilar tip aneurysm and SAH. There were 38 patients with 57 (26%) asymptomatic aneurysms (patients who had symptoms not related to SAH or cranial nerve

Table 3
Number of Aneurysms: 220

F = 104 67%
M = 51 33%

Number of Patients: 155 Location of Aneurysms			Ruptured	Incidental	Asymptomatic
Internal carotid posterior communicating:	93-	42%	46	22	25
Middle cerebral artery:	46-	21%	24	8	14
Anterior communicating:	30-	14%	25	4	1
Basilar artery:	21-	10%	10	7	4
Internal carotid bifurcation:	10-	5%	5	1	4
Anterior cerebral:	8-	4%	4	2	2
Posterior cerebral:	7-	3%	1	1	5
Anterior choroidal:	3-	1%	0	1	2
Vertebral artery:	1-	.004%	1	0	0
PICA:	1-	.004%	1	0	0
TOTAL:			117	46	57

involvement) discovered upon investigation of another neurologic problem. A total of 46 (21%) unruptured aneurysms were discovered "incidentally" during the investigation of another ruptured aneurysm. This group is listed separately because the complications may be associated with the ruptured aneurysm treated at the same time or at a separate time. The total number of unruptured aneurysms could be considered to be 112. The patients with ruptured aneurysms were in Grades I to IV of Botterell's classification. The distribution of patients by sex and age is shown in Table 2, with a definite prevalence in females. The peak incidence was between the 4th and 6th decades of life. The condition at admission by grades is seen in Table 2. The location of aneurysms most frequently seen was the internal carotid. This includes those at the posterior communicating artery (93 aneurysms, 42%) followed by those on the middle cerebral artery (30 aneurysms, 14%). (See Table 3)

The size of the aneurysms also varied from 2mm to the giant size of 2.5cms or larger. The highest incidence (61%) occurred in the 4 to 10 mm range.

Ninety-three patients (60%) had excellent results, 48 patients (30%) had good results, 10 patients (6%) had poor results and 4 patients (3%) expired postoperatively. Two patients with ruptured middle cerebral artery aneurysms died, one in Grade III from reaccumulating temporal lobe hematoma due to the ruptured aneurysm, the other in Grade II following myocardial infarction four days after surgery. The third patient with an internal carotid artery aneurysm had surgery eight days following SAH while in Grade II with angiographic evidence of severe spasm. This patient died four days postoperatively due to massive cerebral edema and infarction that did not respond to medical treatment. The fourth patient in Grade I expired two days after discharge due to a massive pulmonary embolism. This patient has surgery for an anterior communicating artery aneurysm and had been on aminocaproic acid for 12 days preoperatively. All four were patients with SAH. There has been no mortality among the patients with unruptured aneurysms.

Thirty-seven complications in the entire group of patients were presented after surgery. These included one of thrombophlebitis, seven cases of pulmonary embolism (six were on aminocaproic acid), three hemiparesis, one hemiplegia and six infections, (one associated with osteomyelitis of the bone flap which ultimately led to cranioplasty). Two had occlusion of the parent vessel of the aneurysm, one at the internal carotid artery and another at the middle cerebral artery. Neither of these had neurological sequellae due to good cross flow and collateral circulation. Other complications included superficial thrombophlebitis in one patient, seizures in two, and epidural hematoma which was successfully evacuated in one other. Ten patients had post-op III nerve palsy usually associated with basilar artery aneurysm which recovered in an average of two months. Three patients had clinically significant vasospasm. Some postoperative complications were associated with the clinical picture

Table 4

	2-3 mm	4-10 mm	11-20 mm	21 & over
Internal carotid posterior comm. aneurysms	17	33	2	6
Anterior communicating	1	14	0	3
Basilar artery	1	13	0	4
Middle cerebral artery	2	18	0	12
Anterior choroidal	3	0	0	0
Anterior cerebral	0	4	0	2
Internal carotid bifurcation	0	6	0	1
Posterior cerebral	1	3	0	1
Posterior inferior cerebellar artery	1	0	0	0
Vertebral artery	0	1	0	0
TOTAL: 149 = 67%	26 = 18%	92 = 61%	2 = 1%	29 = 20%

of SAH. Seven patients needed shunting procedures for hydrocephalus associated with the SAH after the initial craniotomy for obliteration of the aneurysm. Ten patients had severe vasospasm, but it was clinically significant in only three.

Discussion

Intracranial aneurysms and their complications are still a formidable problem in spite of technical advances. The results of microsurgical techniques have improved the prognosis and the surgical mortality rate is approaching an irreducible minimum but the early mortality from ruptured aneurysms is considerable. Results must be carefully evaluated, not only on the basis of the patient's "grade" due to the bleeding, but the overall medical condition, age and associated problems. Many patients die or never regain enough function or sufficiently improve their condition to justify surgery. There were 16 patients admitted with SAH due to ruptured aneurysm in Grade IV to V who never regained consciousness and expired prior to surgery. Two patients in Grade III rebled prior to surgery. These patients were not included in this study.

Early surgery (before the second week of the initial bleeding) has the advantage of preventing rebleeding and permits more aggressive treatment if a complication arises after clipping the aneurysm. Medications for arterial spasm that otherwise cannot be used because of the aneurysm risk of rerupture may then be tolerated. The problem of postoperative spasm has yet to be solved and is a cause of disability following SAH, although new treatments may offer more hope. Other complications such as hydrocephalus, hematomas and pulmonary embolism complicate the final result.

There is a difference of opinion regarding the management of the incidental, unruptured, and the "asymptomatic" aneurysm. McKissock, *et. al.*, in 1964,[15] and Paterson and Bond in 1973,[16] did not think that treatment of an unruptured asymptomatic aneurysm was indicated. Heiskanen and Martilla,[17] suggested clipping an incidental unruptured aneurysm if it could be reached through the same approach used to treat the symptomatic aneurysm, but they did not advocate a second operation to clip it.

Recently, an increasing number of surgeons have advocated a more radical approach to the unruptured aneurysm.[18,19] Recent data indicate the risk of bleeding and associated mortality from an unruptured aneurysm. Drake and Girvin[20] found that 17% of their patients at risk bled from a previously unruptured aneurysm. Mont and Brisman found,[18] in reviewing the natural history of unruptured aneurysms, that 10% of patients bled and 4% died over an average period of only five years. This indicates that an unruptured aneurysm is not as benign as had been believed.

Conclusion

These cases indicate the probability of good results in the treatment of ruptured and unruptured aneurysms when medical treatment is initially used followed by obliteration of the aneurysm using operative microscope and when the patients are operated on by a surgeon using microvascular techniques.

Surgery of multiple aneurysms should be done at the same craniotomy if the other aneurysm(s) are within reach, or at another craniotomy if the aneurysm is in the opposite side or cannot be reached in the initial surgical procedure. "Asymptomatic" and other unruptured aneurysms in this series have been operated with no mortality and low morbidity. I believe that all aneurysms should be operated upon when diagnosed if the patient's medical condition is satisfactory.

Surgery should be scheduled as soon as possible

for patients with III nerve palsy and no SAH and other Grade I patients, and before the second week for stable Grade II to Grade III patients. Early surgery may reduce mortality from rebleeding and vasospasm.

The mortality and morbidity of patients with spontaneous SAH remains high.[1] The cases that eventually are operated on are a small group. Warning symptoms of ruptured aneurysms are not frequently recognized and investigated. If patients are identified, admitted, diagnosed, and operated on within two weeks of the bleeding, the mortality and morbidity should definitely improve. All physicians, primarily medical and emergency room physicians, should learn the warning symptoms of SAH and start the referral process promptly. ◀

Acknowledgment

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Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR, M.D., CONTRIBUTING EDITORS

Surgical Grand Rounds are held weekly on Tuesday, 5:00pm in the Offield Auditorium of the Passavant Pavilion of the Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 25, 1981.

Second Primary Lung Cancer

Dr. Steven Immerman: This presentation involves two patients. One has a second primary lung carcinoma and the other appears to have recurrent carcinoma. The first patient is a sixty-five year old black man with a fifty pack per year smoking history, who presented in 1977 with an abnormal chest Xray. He was bronchoscoped and a tumor was seen in the posterior segmental bronchus of the right upper lobe. Biopsy revealed squamous cell carcinoma. There was also a nodule in the right main stem bronchus, approximately 1.5cm from the carina. A biopsy was not obtained but the lesion was thought to be carcinoma also. The patient was not referred to the surgical service at that time. He was considered unresectable because of the proximity of the tumor nodule to the carina.

The patient was treated with 5700 rads of radiation to the right upper lobe and mediastinum. After 5700 rads of radiation, his chest Xray cleared. The patient continued to smoke. In 1981, he had a follow-up chest Xray, which revealed a lesion almost identical to the one in 1977. Bronchoscopy was performed and a tumor was again detected in the posterior segmental bronchus of the right upper lobe. However, tumor was not detected between the carina and the right upper lobe bronchus. The tumor was biopsied and again was reported as squamous cell carcinoma. A biopsy was obtained of the right main stem bronchus and normal mucosa was found.

Thoracotomy was performed and a right upper lobectomy was accomplished. Mediastinal lymphadenopathy was not present, nor were there grossly enlarged hilar nodes. Minimal reactions or adhesions in the thorax between the lung and the parietal pleura were seen. Pathologic examination of the resected lung revealed a tumor 2cm in size, without hilar or lobar lymphadenopathy. This lesion was T1,N0, M0, and therefore classed as Stage I.

Second Patient

The second patient is a 58 year old black man, who had a left pneumonectomy in 1972 for squamous cell carcinoma of the lung. At that time, he had a tumor that was $7 \times 5 \times 6$cm in size, with lymphatic invasion. Lobar and hilar lymph nodes were involved with visceral pleural involvement. Thus, the lesion was T2, N1,M0, and classified as Stage II carcinoma of the lung.

Postoperatively, he received chemotherapy (cytoxan and methotrexate) for 18 months. Follow-up chest Xrays were obtained every six months. In 1981, a lesion was detected in the right lung at the level of the third anterior interspace, visible only on the AP film. After this operation, he had good exercise tolerance, but continued to smoke.

A CT scan of the lung was obtained to determine whether this lesion was peripheral or central. The lesion was found to be posterior and peripheral, without other evidence of neoplasm. Thoracotomy was undertaken and a peripheral lesion, 1cm. in diameter, was found without mediastinal or hilar lymphadenopathy. A wedge resection of the superior segment of the right lower lobe was performed. Examination of the specimen revealed squamous cell carcinoma of the lung, 1cm. in diameter without lymphadenopathy. Thus, this lesion is T1, N0, M0 or Stage I. The patient was urged again to stop smoking.

Dr. Thomas W. Shields: We thought that these two patients might be of some interest, as they represent variations in lung cancer. The first patient demonstrates a number of important features. In retrospect, the patient probably had a Stage I disease at the time of his original diagnosis in 1977. It is unlikely that the nodule in the proximal portion in the right main stem bronchus was tumor. Therefore, the radiation was inappropriate therapy. Nonetheless, it does show that radiation can control some tumors for a period of time. Several years ago, Sweet of England irradiated a number of Stage I lesions, and reported a 22% five-year survival. Our patient had a recurrence of his tumor before the fifth year.

Usually, a mediastinotomy would have been performed in this patient because of the question of operability. However, we were concerned that he had received a curative dose of irradiation and felt that the tissue planes might be obliterated, thus increasing the risk. Therefore, exploration of the chest rather than mediastinotomy was elected as a preoperative diagnostic staging procedure.

Follow-Up Data

Interestingly, although we have performed a number of pulmonary resections in patients who have received preoperative irradiation four to eleven weeks after irradiation, this is the first that we have explored more than four years after radiation therapy. The lack of pleural adhesions was impressive and the dissection was relatively easy. It was obvious that the margin of the tumor was distal to the bifurcation of the right upper lobe bronchus and that a lobectomy could be undertaken as a curative operation. The patient has a T1,N0,M0 lesion, which is associated with a 55-75% five-year survival.

The second patient demonstrates a more frequently encountered problem in patients with carcinoma of the lung. Approximately .5% of all patients with carcinoma of the lung will develop a second primary lesion at some time during their lifetime after the initial tumor has been discovered. Now 0.5% seems to be small because only 5% of patients who are found to have carcinoma of the lung survive five years. However, in patients whose disease is sufficiently limited to permit a definitive resection, the incidence of a second primary varies between 2-3%, usually sometime after the fifth year. In most patients who develop recurrent disease within the five years, the disease represents a recurrence of the original primary. It is often difficult to determine if a lesion is a recurrence or a new primary after resection for carcinoma of the lung. This is only certain if the two tumors have different cell type. However, most lung cancer is squamous cell carcinoma so that the same histology does not exclude a second primary. Some of the second primaries indeed have a different cell type, adenocarcinoma or oat cell.

Follow-up study of our patients has led us to conclude that 10-12% of patients who survive five years after definitive resection will develop a second primary lung tumor, a significant incidence. Unfortunately, only 30% of these patients will have a resectable lesion at the time the new second primary is discovered.

In the VA study, we report an approximately 30% five year survival for all stages following pulmonary resection. By 10 years, it has decreased to approximately 12%. The five year survival has been reported higher, in series from private clinics, particularly for stage I disease, where the ten year survival is nearly 20%.

In general, the ten year survival is half the five year survival. However, after the fifth year, most patients die of a disease other than their lung tumor or some other tumor. In our VA series, 257 patients survived 10 years, 69 survived 15 years, and a few have survived 20 years or longer. Most will die of heart disease or respiratory disease. However, approximately 20% will develop a second primary malignant neoplasm, of which half will be in a site other than the lung and half will be in the lung itself.

Second Primaries

The most frequent sites of extrapulmonary new primary cancer are in the urinary tract, the large bowel, larynx, and oropharynx. Those patients who

survive the first cancer have a greater propensity to develop a second malignant neoplasm than does the normal population. They require continuing surveillance through their remaining lifetimes.

As I stated earlier, only about a third of the patients who develop a second primary lung cancer will have a lesion so situated or of the proper cell type as to be amenable to resectional therapy. Some second primary cancers are oat cell carcinomas which are not surgical lesions. In addition, this group of patients usually continues to smoke after the first resection. Almost every patient who develops a second primary lung carcinoma has continued to smoke.

When the second primary occurs in the ipsilateral lung following a limited resection, lobectomy or less, one has the option of doing a wedge resection or a segmentectomy. More often, one is required to do a completion pneumonectomy. This may be difficult because of the previous dissection, but it can usually be carried out without a high complication rate.

In contrast, when a pneumonectomy has been the first procedure, one is more limited because the amount of remaining lung tissue results in limited pulmonary function. One is limited really to either a segmentectomy, or if possible, a wedge resection, because it is followed by fewer complications. An adequate wedge resection in the absence of palpable involved nodes probably is as satisfactory as a segmentectomy. Our last five wedge resections after pneumonectomy were accomplished without postoperative complications. Cooperation from the anesthesiologist is essential.

Summary

In summary, there are two important points. First, patients must be followed carefully after curative resection for lung cancer. If a lesion develops in the remaining lung tissue, it should be considered to be a new primary when solitary, unless obvious metastases are found elsewhere. That patient should be evaluated preoperatively, as should any patient with a pulmonary lesion. A resection should be performed if feasible.

Second, the initial procedure in a patient with carcinoma of the lung should be the most conservative resection commensurate with the patient's disease. In the absence of lymph node metastases, a segmentectomy or a lobectomy is satisfactory. Pneumonectomy should be reserved for instances when a lesser procedure cannot be carried out or when lymph node metastasis is present. ◀

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Pulse of the ISMS Auxiliary

Communication

By Susanne Webb/ISMSA President

Communication takes many forms, both verbal and nonverbal. It is essential to smooth group functioning and to prevent misunderstanding. Brevity and clarity are the two qualities to strive for.

In oral communication it is necessary to be as explicit as possible. Never assume that the person with whom you are communicating will understand the same things that you do. He or she may have a different frame of reference. An excellent tape cassette of a recent AMAA Confluence workshop on oral communication is available from the ISMS Auxiliary.

When asking an auxilian to take a job, explain fully what time and effort are required and the responsibilities that are entailed.

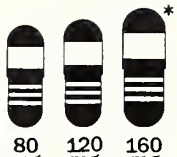
We have several valuable forms of written communication in the federation of county, state and national auxiliaries. Several counties send out a newsletter one or more times a year. The ISMSA publishes "Pulse" four times a year. The ISMSA president writes a monthly article in the *Illinois Medical Journal.* ISMS sends "On the Legislative Scene" to the auxiliary leadership. It is an excellent way to keep us aware of current concerns and we can be of assistance to the ISMS by responding to the red alerts that are occasionally received.

The AMA Auxiliary has many publications. "Facets" is a well edited magazine full of items of interest and suggestions for and reports of auxiliary activities. "Direct Line" keeps us updated on the latest information available. There is also a catalog of AMAA publications to be had for the asking from the AMAA office in Chicago.

There are letters from national and state officers and chairmen. In response to comments from the membership, we are trying to keep these to an essential minimum and achieve brevity and clarity.

We need information, opinions and reports on activities from the counties for both "Pulse" and "Facets." Communication is a two way street. Send pictures of your auxiliary in action. The Auxiliary continues to have a problem with the image that we project. With improved communication we can change the incorrect perceptions that others have of us as a group. ◀

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride
(80 mg, 120 mg, 160 mg Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. **8511/783**

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New York, N.Y. 10017

History of the Division of Urology Of the University of Illinois College of Medicine

By Joseph H. Kiefer, M.D./Chicago

This short historical sketch of the Division of Urology of the University of Illinois College of Medicine was written as part of the program celebrating the centennial year (1882-1982) of the University's College of Medicine. This sketch is not meant to be comprehensive, but only to enumerate what might be called the highlights and important events during the first 100 years.

The College of Medicine began as the College of Physicians and Surgeons of Chicago (P&S). The founders of the school were five in number: Charles Warrington Earle, Abraham Reeves Jackson, Daniel A. K. Steele, Samuel A. McWilliams, and Leonard St. John. The idea of starting a new school had been broached by Earle in 1876, but five years passed in discussion and planning before the preparations were completed and a charter obtained in 1881. In 1882 the first class of 100 students was admitted. A complete and authoritative history of the school as a whole is being written by Patricia Spain Ward; matters of general import will be touched on only incidentally in this narrative.

In the first catalogue and announcement in 1882, the list of faculty and course subjects shows that genitourinary disease was considered a separate field. Theodore A. Keeton, a graduate of Jefferson Medical College in Philadelphia, was named as professor of genitourinary diseases and G. Frank Lydston as lecturer. Dr. Keeton's tenure was brief; the next catalogue, dated 1883, shows him replaced as professor by James T. Jelks, with Lydston continuing as lecturer.

Dr. Jelks, born in Alabama and a graduate of the University of Nashville Medical School, apparently divided his time between Chicago and Hot Springs, Arkansas. Probably he came to Chicago for a term to give his lectures and then returned to continue private practice among the people who, then as now, converged on this popular spa, especially in the winter months. He was also on the staff of the West Side Free Dispensary (the clinical facility of the school), as was Lydston, who undoubtedly covered the dispensary and clinic service and taught during Jelks' absence in Hot Springs. This arrangement apparently continued unaltered for seven years, until 1891.

In the 1890-91 roster Jelks had as assistants Henry J. Reynolds, who practiced in the fields of dermatology and venereal disease, and James P. Letts. After this time Jelks' name no longer appeared. G. Frank Lydston, listed as lecturer since the opening of the school, was named professor of surgical diseases of the genitourinary system in 1891 and continued as head for 21 years, until 1913, when the school was reorganized and became an integral part of the University of Illinois.

Lydston, born in 1858 in New York, was a well-known and colorful character. A graduate of the Bellevue Hospital Medical School in 1879, he must have very early decided to confine his practice to urology. His name appears on that faculty list on the opening of the school three years later, in 1882.

At that time a urologist treated conditions of the lower urinary tract.[1] These most commonly included infections of the bladder and urethra and diseases of the external genitalia, many of which were of venereal origin. The sequelae, especially urethral stricture, often required treatment (such as urethral dilatation) for years and sometimes for a

JOSEPH H. KIEFER, M.D., a baard certified uralagist, is prafessar emeritus and farmer chairman of the UI College af Medicine divisian af uralagy. He was the head of the uralagical divisian far both St. Jaseph Haspital and the University of Illinois Hospital. Dr. Kiefer is a past president of the Chicaga Uralagical Saciety, the Society of Medical History of Chicago and the Catholic Physicians Guild af Chicaga.

lifetime. As a result, most urologists became very adept at urethral instrumentation and treated bladder stones transurethrally by lithotrity. They also began to use the cystoscope, both for diagnosis and treatment, after its invention by Max Nitze about 1880. At that time the urologist did little or no open surgery, but as cystoscopic diagnosis of upper tract urinary disease became more accurate, urologists began to do major open surgery, beginning in Chicago with William Belfield,[2] about 1885.

Lydston was the author of at least eight books on urologic subjects, including a textbook, SURGICAL DISEASES OF THE GENITO-URINARY TRACT (1899) which was reprinted in several editions. He also fancied himself as a raconteur and published a lengthy series of fictional medical anecdotes under the title OVER THE HOOKAH, in 1896. He also wrote numerous shorter works on sexual disease and social conditions. At some time, probably in his later years, he carried out experiments in sex gland transplantation, using animals on his farm.

During the 21 years in which Lydston was a professor, a constantly changing list of names appeared as instructors and/or assistants. R.A. Sempill was named in 1892, immediately after his 1891 graduation. He left in 1894. With him in 1892 was listed Robert L. Nourse, an 1889 Rush Medical School graduate, who stayed only a year. He was replaced in 1893 by Frederick A. Leusman, later a charter member of the Chicago Urological Society, who also stayed only a year. Added in 1893 were August M. Unger, an 1892 P&S graduate who also lectured at the Chicago College of Pharmacy (UI), and Harris E. Santee, a University of Pennsylvania graduate of 1892, who stayed on until 1895. Replacing Santee in 1895 was Buell S. Rogers, an 1892 Rush graduate who remained until 1899. He went into military service and eventually became assistant surgeon general.

In 1897 an agreement of affiliation was concluded with the University of Illinois. This did not change the name, the ownership, or the direction of the school and seems not to have had any effect on the faculty. This year Wallace McM. Burroughs was appointed as instructor and continued until 1909. He was a graduate of Northwestern University Medical School and on the staff of the Wicker Park Hospital. In 1897 George M. Silverberg, a University of New York graduate in 1893, was appointed, but stayed only a year. He was replaced in 1898 by Henry E. Wagner, a P&S graduate of 1895 who was also on the staffs of Illinois Masonic Hospital and St. Joseph Hospital. In 1899 Aimé P. Heineck, who was born in France and graduated from Northwestern in 1896, was listed and remained until 1909. He later held staff appointments at a number of Chicago hospitals, including



Professor G. Frank Lydston (1858-1923). Founding faculty 1881, Ch.Div. 1890-1913.

the Cook County Hospital, and had faculty appointments at several other medical schools.

Also in 1899, there first appears the name of Daniel N. Eisendrath, a Chicago native and 1891 graduate of Northwestern. While he is listed with the genitourinary faculty, his appointments were as lecturer in surgical pathology and clinical instructor in surgery. He did major open surgery of the genitourinary tract, which, until that time, had been done by general surgeons. Eisendrath concentrated on urology and later (in 1928, with co-author Harry Rolnick) published a very popular textbook of urology, which went through four editions and revisions (by Dr. Rolnick). In 1907 Eisendrath was listed as adjunct professor to Lydston, and when the latter left in 1913 he was appointed professor. In 1917 he left Chicago and went to France with the U.S. Army. On his return, after the war (WWI), he did not return to the faculty, and eventually he returned to Paris on the staff of the American Hospital there. While in Chicago he had served on the staffs of the Cook County and Michael Reese hospitals. Although he apparently did major open urological surgery, his name appears only sporadically on the urology faculty lists until the reorganization of 1913.

In 1910, Budd C. Corbus was appointed assistant professor and stayed until 1913. A native of LaSalle, he graduated from the P&S in 1901. He confined his practice to urology from the beginning and was very active and prominent in the affairs of



Professor Charles Morgan McKenna (1879-1945). Joined faculty 1913, Ch.Div. 1918-1945.

the Chicago Urological Society, serving as its president in 1914. He practiced in the suburb of Evanston. He later helped develop the Corbus-Ferry vaccine from the exotoxin of the gonococcus.

Also, in 1910, Edward W. White, just graduated that year from P&S, was named as assistant in anatomy, but was listed on the urology faculty until 1913. He became president of the Chicago Urological Society from 1918-20. The year 1912 shows the addition of three new staff members, but they remained only one year. Louis W. Bremerman, who graduated from Jefferson Medical College in 1900, was named associate professor. He had been on the University of Iowa Faculty and was later at Loyola University. He had a private urological hospital on the South Side of Chicago. Harold H. Steere, a P&S graduate of 1908, and John B. Legnard, a Northwestern graduate of 1902, served as instructors for this year.

A Major Restructuring

The year 1913 was a momentous one for the entire school. Although affiliated with the University of Illinois since 1897, the College of Physicians and Surgeons was still a privately owned corporation. Attempts to sell the school to the university came to nothing through failure of the necessary appropriation legislation. Finally, a group of alumni became interested, persuaded some of the stockholders to contribute their interest, raised money to buy out the rest, and presented the school to the University of Illinois. This was accompanied by a complete reorganization of the faculty, the P&S name was dropped and it became the University of Illinois College of Medicine.

Changes in the urology faculty were profound. In urology only Eisendrath carried over. Lydston left, after 31 years. Besides Professor Eisendrath, three new names appeared as instructors, all men who restricted their practices to urology and later became prominent in urological affairs in Chicago.

The first man, French S. Cary, was born in Virginia, graduated from the Baltimore College of Physicians and Surgeons in 1906 and had postgraduate training at Johns Hopkins Hospital for two years. He practiced at the University and Englewood Hospitals and was president of the Chicago Urological Society in 1921.

The second, Charles Morgan McKenna (1875-1945) was born in Wisconsin. He was on the staffs of St. Joseph and Cook County Hospitals, and served as president of the Chicago Urological Society in 1922, and, later, of the North Central Section of the American Urological Association.

The third, Irvin S. Koll, born in Kentucky, graduated from Rush in 1907. He was a member of the staff of Michael Reese Hospital and president of the Chicago Urological Society in 1917 and again in 1930.

Elmer W. Schnoor was named as an assistant at this time.

One year later, in 1914, another assistant was Raymond F. Elmer. In 1915 Koll left, and in 1917 Eisendrath left and Cary became assistant professor and chairman in his place.

The involvement of the USA in World War I brought a disruption of the urology faculty. All were eventually in military service. In 1918 Cary left and McKenna became chairman of the division with faculty members Harry J. Smejkal, John P. O'Neill and Harry Culver, all full-time specialists in urological practice. From 1913 on, all members of the faculty were specialists in urology, with the occasional exception of a few clinic assistants or instructors who showed interest in urology, but were not fully trained. If they did not continue in urology, they were dropped after a year or two.

From this point on no attempt will be made to note every member of the faculty in this account. A full listing by years is given in Appendix I and a short biographical sketch of everyone in the alphabetical list is also available (*see Editor's note*).

Postwar Evolution

After World War I ended and those in military service returned, the urology division settled down. Dr. Charles Morgan McKenna was chairman. A graduate of Rush, he received his urologic training under Gustav Kolischer, the second great pioneer of urology in Chicago after William T. Belfield. McKenna joined the University of Illinois faculty in 1913 at the time of reorganization. He served in the Army Medical Corps in World War I. On his return in 1918 he was named division chairman, a post he held until his death in 1945 (32 years on the faculty—27 years as chairman). A tall, striking figure, he was an excellent teacher, impressing unforgettably on his students the important facts that he wished them to remember. A good surgeon, and with an outgoing personality, he won the respect and friendship of his urologist colleagues, both locally and on a national level. He was voted to the presidency of the Chicago Urological Society and the North Central Section of the American Urological Association.

He was on the staffs of St. Joseph and Cook County Hospitals and the Municipal Tuberculosis Sanitarium.

Dr. McKenna set about to build an excellent faculty and in the five years after his appointment he attracted three men who, each in his own right, were to become pre-eminent in Chicago urology.

The first of these, Dr. Harry Culver, (1885-1958) joined the faculty in 1918 on his return from military service. His urologic training was with Dr. Frank Phifer, who had inaugurated the first separate urologic service at the Cook County Hospital in 1913. Dr. Culver became head of the Cook County Hospital urologic service and remained such for many years. He was a leading figure in Chicago and national urologic circles. A forceful teacher and a good surgeon, he resigned from the University of Illinois to join the Northwestern University Medical School faculty in 1927.

Another was Dr. Vincent J. O'Conor (1893-1963). Born in downstate Illinois and a Rush graduate, he completed urologic training under Dr. William Quimby at the Peter Bent Brigham Hospital in Boston. He joined the urology faculty in 1922. O'Conor was an excellent clinician with a most pleasant manner and personality. He, too, rose to the highest levels in local and national urologic circles. He remained at the University of Illinois for 20 years, then resigned to join the faculty of Northwestern University Medical School, where he became division chairman, a post he held for 15 years until his death in 1963.

The third eminent faculty acquisition in the 1920's was Dr. Russell D. Herrold (1888-1960),



Professor Russell Dorr Herrold (1888-1960). Joined faculty 1922, died 1960.

also a Rush graduate. He was unusual in that he was strictly a medical urologist and did no major surgery. His training was basically bacteriologic; he had trained at the John McCormick Institute for Infectious Diseases, then the leading center for study in this field, under the leadership of the famous Ludwig Hektoen. His name became known nationally through his invention of the Herrold medium, for decades the best culture medium for isolation and growth of tubercle bacilli. During World War I his bacteriologic expertise was put to very good use in urologic cases. After the war, he continued to do urologic bacteriology exclusively, much of it in difficult and resistant cases referred to him by his urologic colleagues. Herrold became known as the urologist's urologist. He maintained a laboratory in conjunction with his office and did his own cultures and readings. When the sulfa drugs (c 1937) and antibiotics (c 1941) became available, he was a pioneer in determining the sensitivities and resistances of the various types and strains of bacteria to these drugs. He continued these studies even after his retirement as professor emeritus in 1957 and they ceased only on his death in 1960.

During the early 1920s, the clinical teaching facilities were enlarged by affiliation arrangements with various hospitals. Thus, for varying intervals, several well-known urologists appear on the faculty listings. These included Drs. Louis E. Schmidt and Harry Kraus at Grant Hospital, Drs. Wm. T. Belfield, Harry Culver and William Bradley at University Hospital, Dr. Robert H. Herbst at the

Chicago Policlinic, Dr. John Nagel at the West Side Dispensary and Hospital, and Drs. Gustav Kolischer and Harry Katz at Mt. Sinai Hospital. Dr. McKenna held clinics at St. Joseph Hospital.

The need for outside clinical facilities ended with the 1925 opening of the new Research and Educational Hospitals of the University of Illinois with its associated dispensaries and outpatient clinics.

About this time, changes in the administrative arrangements of the faculty split off the surgical specialties of orthopedic surgery, ophthalmology, otolaryngology, and neurosurgery. They were set up as separate departments. Urology, however, remained a division of the department of surgery. Its bed count, patient and surgical numbers were included in the surgical department statistics to bolster them. For the first 15 years, the surgery residents spent one-third of their time on the urology service. At least three of them took additional training and specialized in urology.

This failure to give urology the same independent status as the other surgical specialties had serious detrimental effects on the division. It held up the urology residency training program until 1955 and seriously affected recruitment of top level faculty. It has led to intrusion of extra-urologic factors into important decisions relating to the division.

The plan of instruction in the genitourinary division, as in nearly all of the specialty divisions, called for teaching during the last two years, the so-called clinical years. In the early years, the introductory courses consisted of lectures, usually by the professor and division chairman, to the entire class, which reviewed the diseases and conditions included in the clinical specialty. The relevant basic anatomic and pathologic facts were reviewed and the treatment was outlined. Later, as the classes became larger, they were divided into smaller groups, which took on seminar-quiz format.

Clinical courses were arranged for smaller groups in the dispensaries or clinics. Here the student had immediate contact with patients and the opportunity to learn diagnostic and treatment techniques. The students could absorb some of the art of medicine by seeing their teachers, who were also practitioners, as they questioned, examined and treated their patients.

This general plan of instruction was followed with minor variations until the 1960's when all didactic instruction (lectures, quiz groups, seminars) was stopped. Students now started hospital and dispensary clerkships directly from their basic science studies. Presumably, they were to read a text and this was to supply the material formerly given in the didactic and quiz courses. [Many students neglect this, and those who do cannot derive full benefit from their time with patients, because they do not have an adequate idea of the clinical pictures of disease, or even the vocabulary of the specialty. It is a great waste of the student's clinical time, as well as the teacher's time, to spend a large fraction of the bedside time explaining basic facts to small groups, when such facts could be better presented in a more organized fashion to large groups, or even the whole class at once, in the lecture room.]



Professor Joseph Henry Kiefer (1910-). Joined faculty 1937, Ch.Div. 1945-65, 1969-76.

In 1930, Dr. Earl E. Ewert, a graduate of the University of Illinois in 1926, joined the faculty. He had finished the urology residency program at Cook County Hospital, at that time the only one in Chicago. He was a well-liked teacher, a fine clinician with an agreeable personality. In 1937 he was offered the position of head of the urology staff at the Lahey Clinic in Boston and he resigned to accept the appointment. He continued there until his retirement.

His place was taken by Dr. Joseph H. Kiefer, a native of Chicago and a graduate of Northwestern. He served his internship at Cook County Hospital and continued as a urology resident there. He came immediately to the University of Illinois to take the place of Dr. Ewert in 1937. His private practice was centered at St. Joseph Hospital and Augustana Hospital.

Other Important Figures

Several other teachers who joined the urology division faculty during the 1930's were to provide for many years, important help in the teaching

program. In 1933 three men first appeared: Drs. John T. C. Gernon, Frederick W. Schacht, and C. Otis Ritch. Dr. Gernon, a UI graduate, had served under Dr. Herman L. Kretschmer at the Presbyterian Hospital. A cousin, Gerald D. Gernon, had served for a year (1921-22) as a dispensary assistant in the urology division, but had not gone further. Dr. John Gernon became a certified specialist and served on the faculty until 1946. Dr. Fred Schacht, a graduate of Johns Hopkins, received his urologic training at the Mayo Clinic and Johns Hopkins. He served on the teaching faculty for over 30 years and retired as associate professor emeritus in 1966. Dr. C. Otis Ritch, a graduate of Emory University Medical School, received his urologic training under Dr. Edward White, who had been an assistant in the division from 1910-13. Dr. Ritch also retired as assistant professor emeritus in 1966. In 1937, Dr. Joseph S. Drabanski, a graduate of Loyola University School of Medicine, who completed his urologic residency at Cook County Hospital, was appointed. Except for his World War II army service, he stayed on for about 30 years, when ill health forced him to request inactive status. He died in 1972.

After the opening of the new hospital in 1925, it became the state referral point for difficult and unusual cases. For the urology division, this group included urinary and genital anomalies, particularly undescended testes, hypospadias, epispadias, bladder exstrophy and other sexual and urinary tract anomalies. The group included cases of uncertain or indeterminate sex, the so-called intersex states or hermaphroditism. In close cooperation with the pediatric staff and endocrinologists, especially Drs. I. Pat Bronstein and, later, Ira Rosenthal, a large series (over 100) of these sex anomalies were satisfactorily treated. Adrenogenital syndrome, the largest single group, was first treated by bilateral subtotal adrenalectomy, superseded in the 1950s by medical therapy. The division was the first in the Midwest to use the Barr chromatin body test (Murray L. Barr, 1949) with the active and willing cooperation of Dr. Elizabeth McGrew of the pathology department. She and Dr. Frederick V. Wood also cooperated in a study of cells sloughed from papillary bladder tumors. The study focused on their viability in various media and their potential for implantation on raw and intact surfaces.

The advent of the antibacterials, the sulfas and the antibiotics, markedly changed urologic therapy. The urology division was in the forefront of this therapeutic revolution because of the work of Dr. Russell Herrold who carried on a continuous pioneering investigative program with these drugs, using new drugs and materials supplied by the drug manufacturers before they were available on the open market. His results and opinions were widely sought.

Dr. Herrold was also a pioneer in the endocrine treatment of prostatic cancer. He was the first in the Chicago area to use the synthetic estrogen stilbesterol in the treatment of this disease. He reported his results in his first series of cases to the Chicago Urological Society at the same meeting (1941) at which Dr. Charles Huggins reported his first cases treated by surgical castration. Although the idea of endocrine treatment was not new, (it had been worked out and used many years before) Dr. Huggins later received a Nobel Prize for related work. Dr. Herrold continued his interest, evaluating the use of estrogens, alone and in combination with orchidectomy and adrenalectomy, after he became professor emeritus in 1957 and until his death in 1960.

In 1942, Rush Medical College decided to end ties to the University of Chicago. It had long been affiliated with the University of Chicago and for many years the first two (or basic science) years of the medical course had been offered only at the University of Chicago Midway campus. About 1940, the University of Chicago announced that it would no longer continue the current affiliation and asked Rush to become a part of the University of Chicago. This would include transfer of all Rush endowment funds to the University of Chicago. Rush refused to agree to this, and the affiliation ended. Rush then approached the University of Illinois and an affiliation agreement was reached whereby clinical third and fourth year University of Illinois students would be assigned to the Rush facilities and the Rush staff would receive faculty appointments at the University of Illinois. This continued for 30 years.

The Rush affiliation caused an immediate large increase in the faculty list, and in urology included several well-known men. Among them was Dr. Robert W. Herbst, the only survivor of the few men trained by Dr. William Belfield. Another was Dr. Herman L. Kretschmer, (trained by Dr. Louis Schmidt), active in urological and medical politics, who became president of the American Urological Association and later of the American Medical Association. Also in the Rush group were Drs. C. Grafton Weller and Norris Heckel. A few of the Rush faculty came to the University of Illinois to teach, but by and large there was little cross-over between the two groups.

The entry of the United States into World War II caused some disruption in the division, but with the help of the Rush staff teaching functions were well covered.

In May, 1945, Dr. McKenna died suddenly. He

had been fully active until the day of his death. He had joined the faculty in 1913 at the time of the incorporation of the school into the university, and had become chairman of the division on his return from the Army Medical Corps in 1918. He had spent 32 years on the faculty and 27 years as chairman of the division.

On Dr. McKenna's death, Dr. Joseph H. Kiefer, a native of Chicago and Northwestern University Medical School graduate, who had completed his internship and urology residency at Cook County Hospital, was appointed chairman of the division. He had joined the faculty in 1937. By 1945, he was in charge of the outpatient and cystoscopic clinics as associate professor. He continued as chairman until 1959 when he asked to be relieved of this responsibility. This will be dealt with in due course.

Postwar Changes

After the close of World War II a new addition to the faculty was Dr. Cornelius W. Vermeulen, a graduate of the University of Chicago, whose urology residency was served at the Billings Hospital. In addition to being a good surgeon, he was a very active and ingenious investigator in the chemical and animal labs and took over direction of the research lab for general surgery as well as urology. He became known nationally for working out a method of causing urinary stone growth in rats and studying the effect of various factors on their growth and dissolution. He resigned in 1953 to accept appointment as chairman of the urology division at the University of Chicago School of Medicine, where he later became associate dean.

As mentioned above, when the Research and Educational Hospitals were opened, the established surgical specialties were organized as departments, except for urological surgery, which was left as a division of general surgery. Its beds, patient visits, and surgical counts were included in surgery statistics. Its housestaff needs were met by a surgery resident, who spent a full third of his time on the urology service. The rationale was that there were not sufficient beds to sustain both a surgery and a separate urology department and residency program. However, at least three of the surgical residents (Palmer, Pranke, Linke), by taking additional urology training, elected to become certified practicing urologists.

It was not until 1955, with completion of the hospital addition (840 S. Wood St.) that a urology residency program was initiated and approved. It started with a single resident who served three years in urology (with one year equivalent in general surgery) with the number of residents increasing, as available facilities increased, to six in 1981.

In 1958, St. Luke's Hospital, a well-known private hospital, affiliated for many years with Northwestern University Medical School, decided to close and merge with the Rush-Presbyterian Hospital. This brought many well-known urologists as additions to the Rush section of the urology division faculty. These included Dr. William J. Baker, former president of the Chicago Urological Society and of the American Urological Association, Dr. Theophil Grauer, Dr. Edward Graf and others.

In 1959, Dr. Kiefer asked to be relieved of his duties as division chairman for personal reasons. Dr. James H. McDonald, a 1942 UI graduate, had completed his residency at Presbyterian Hospital after his Army service. He had an appointment in the division's Rush faculty from 1948 and had the rank of associate professor. He was appointed co-chairman of the division in 1960 with Dr. Kiefer, and in 1963, on the withdrawal of Dr. Kiefer, he became division chairman. He continued a part-time private practice at Presbyterian Hospital.

Dr. McDonald was very active in urological society affairs as president of the Chicago Urological Society in 1963 and was active in the affairs of the American Board of Urology. In 1969, Dr. McDonald, very suddenly, submitted his resignation for health reasons, and Dr. Kiefer became acting chairman. A search was made for an older, well-known candidate, but this was made difficult by two factors. The most important was the fact that urology was not an independent department in control of its own affairs. Also, facilities for part-time practice were not available.

Dr. Samuel S. Clark, a graduate of McGill University Medical School in Montreal, had also received his urologic training there and had seen service in the U.S. Navy. He was appointed in 1969 as assistant professor to head the urology staff at the West Side Veteran's Administration Hospital, which had recently (1967) become affiliated with the University of Illinois. In turn, the University of Illinois had assumed responsibility for its medical staff and care. Dr. Clark was able to give very valuable assistance in the day-to-day workings of the division at the Research and Educational Hospitals, as well as at the Veteran's Administration Hospital. In 1976, he was appointed acting head of the division and Dr. Kiefer again withdrew.

Dr. Kiefer continued with the division as senior consultant, but devoted an increasing amount of time to the history of urology, especially in the Chicago area. He had collected many books relating to urology, going back to the 15th century. In 1973, he gave 577 items to the University and followed this up with a further gift in 1978, to a

total of over 1,800 items. The collection is in the school library and a catalogue has been published.[3]

In 1977, the University of Illinois assumed responsibility for the supervision of the medical staff of the Cook County Hospital, and Dr. Patrick Guinan, a graduate of Marquette University Medical School who had taken his residency at Cook County Hospital and had remained there as a full-time member of the urology staff, was appointed to the University of Illinois faculty as chairman of the division. His main responsibility continued to be at Cook County Hospital, while the day-to-day running of the University of Illinois fell to Dr. Roohollah Sharifi, a native of Iran and graduate of the University of Tehran, where he had postgraduate training in surgery, followed by very active surgical experience in Viet Nam. He came to the University of Illinois as a resident on the Urology Service 1973-76. When he had completed his residency, Dr. Clark asked him to remain as a full-time member of the teaching and clinical staff with the rank of assistant professor. He was appointed associate professor in 1981. His associate is Dr. Biswamay Ray, a graduate of the University of Calcutta who had a urological residency at Maimonides Hospital in Brooklyn and further oncology training at the Memorial Hospital in New York. Dr. Ray serves in the field of urological oncology.

Conclusion

The first 100 years of the urology division were built around the services of four men who provided a continuity of teaching and clinical service from the beginning. Dr. G. Frank Lydston was on the original faculty in 1881. He became chairman in 1891 and continued until 1913, a total of 32 years on the faculty and 22 years as chairman. Dr. Charles Morgan McKenna joined the faculty in 1913, became chairman in 1918 and continued until his death in 1945, a total of 32 years, 27 years as chairman. Dr. Russell D. Herrold joined the division in 1923 and continued until his death in 1960, a total of 37 years. Dr. Joseph H. Kiefer began in 1937 and became chairman in 1945, continuing almost until the present; more than 45 years on the faculty and 28 years as chairman.

In addition to these mainstays, there were several other faculty members who gave long and faithful service especially in the early and middle years, when the teaching load was much heavier. Deserving of special mention are Drs. Fred W. Schacht and C. Otis Ritch, who served many years until they became emeritus. The many other urologists who gave of their time and effort over the years deserve grateful acknowledgment. All were practicing certified urologists who gave not only of their expertise, but also of their clinical experience in the art of medicine, a facet of practice neglected in recent teaching, which is thought to be an omission much noticed by the public.

The outlook for the future is brightened by a bequest in the will of Dr. Clarence Saelhof, a graduate of the UI in 1922 and a practicing urologist in the Chicago area. During his medical school years, Dr. Saelhof had worked in the department of pathology and bacteriology and received a Master's degree in 1925. After this he continued to work at the John McCormick Institute for Infectious Diseases and for his work there he received a Ph.D. degree from the University of Chicago. He took some courses in urology given by the Cook County Hospital Postgraduate School and was an associate of Dr. John Nagel, who practiced urology on Chicago's West side. While not a member of the faculty, he was a close friend of Dr. Russell Herrold and other staff members. In his will, Dr. Saelhof established a trust which, on the death of his wife, has been designated to support a named professorship in urology. It is hoped that this will enable the division to be established as a separate free-standing department with complete self-determination and control, able to make decisions based completely on its own needs, unhampered by factors unrelated, and at times even harmful to, urology. ◀

Editor's Note

A second appendix to the "History of the Division of Urology of the University of Illinois College of Medicine," which gives biographical sketches of the persons listed in Appendix I, may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

In addition, the original and copies of both appendices are available at the archives of the Library of the Medical Sciences, University of Illinois, Post Office Box 7509, Chicago, IL 60680.

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APPENDIX I
College of Physicians and Surgeons

Urological Faculty—as recorded in The Annual Announcements and Catalogues. There may be a year variance in dates because announcements and catalogues did not always appear the year of appointment.

1882-83	Prof.GU Dis.—Keeton (ch)
	Lect.GU Dis.—Lydston
1883-89	Prof.Surg.Dis.GU System—Jelks (ch)
	Lect.—Lydston
1890-91	Lect.—Lydston (ch)
	Affil.—Reynolds
	Asst.—Letts
1891-92	Prof.Surg.Dis.GU System—Lydston (ch)
	Asst.—Leusman
	Affil.—Corbett, Remman
1892-93	Prof.Surg.Dis.GU System—Lydston (ch)
	Clin.Instr.—Sempill, Nourse
1893-94	Prof.Surg.Dis.GU System—Lydston (ch)
	Clin.Instr.—Leusman, Santee, Sempill, Unger
1894-95	Prof.—Lydston (ch)
	Clin.Instr.—Santee, Unger
1895-96	Prof.—Lydston (ch)
	Clin.Instr.—Rogers, Unger
1896-97	Prof.—Lydston (ch)
	Clin.Instr.—Burroughs, Rogers
1897-98	Prof.—Lydston (ch)
	Clin.Instr.—Burroughs, Rogers, Silverburg
1898-99	Prof.—Lydston (ch)
	Clin.Instr.—Burroughs, Rogers, Wagner
1899-1901	Prof.—Lydston (ch)
	Clin.Instr.—Burroughs, Heineck, Wagner
1901-06	Prof.—Lydston (ch)
	Adjt.Prof.Surg.—Heineck
	Clin.Instr.—Burroughs
1907-1910	Prof.—Lydston (ch)
	Adjt.Prof.Surg.—Heineck
	Clin.Instr.—Burroughs
1910-11	Prof.—Lydston (ch)
	Asst.Prof.—Corbus
	Asst.in Anat.—White
1912-13	Prof.—Lydston (ch)
	Assoc.Prof.—Bremerman, Corbus
	Instr.—Legnard, Steere
UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE	
1913-14	Prof.—Eisendrath (ch)
	Instr.—Cary, Koll, McKenna
1914-15	Prof.—Eisendrath (ch)
	Instr.—Cary, Koll, McKenna
	Asst.—Schnoor
1915-16	Prof.—Eisendrath (ch)
	Instr.—Cary, McKenna
	Asst.—Schnoor
1916-17	Asst.Prof.—Cary (ch)
	Instr.—McKenna, O'Neill, Smejkal
1917-18	Assoc.Prof.—Cary (ch)
	Asst. Prof.—McKenna
	Instr.—O'Neill, Smejkal
	Asst.—Oliver
1918-19	Asst.Prof.—McKenna (ch)
	Instr.—Culver, O'Neill, Smejkal
1919-20	Asst.Prof.—McKenna (ch)
	Assoc.—Culver, Wm.N.Senn
	Instr.—Mars, Mazel, Smejkal
1920-21	Asst.Prof.—McKenna (ch)
	Assoc.—Culver
	Instr.—Mars, Mazel, Smejkal
1921-22	Asst.Prof.—McKenna (ch), Culver
	Instr.—Holderman, Mars, Smejkal
	Asst.—G.Gernon
1922-23	Assoc.Prof.—McKenna (ch)
	Asst.Prof.—Culver
	Instr.—Herrold, O'Conor, Smejkal
	Asst.—G.Gernon
1923-24	Assoc.Prof.—McKenna (ch)
	Asst.Prof.—Culver
	Instr.—Herrold, O'Conor, Smejkal
	Asst.—Van Pelt
1924-25	Assoc.Prof.—McKenna (ch)
	Asst.Prof.—Culver
	Instr.—Herrold, O'Conor, Smejkal
1925-26	Assoc.Prof.—McKenna (ch)
	Asst.Prof.—Culver
	Instr.—Herrold, O'Conor, Smejkal
	Asst.—Hirsch
1926-27	Prof.—McKenna (ch)
	Assoc.Prof.—Culver
	Assoc.—Herrold, O'Conor
	Instr.—Hirsch

1927-28 Prof.—McKenna (ch)
Asst.Prof.—Herrold, O'Conor
Instr.—Hirsch, Schwetzer, Van Hazel

1928-29 Prof.—McKenna (ch)
Asst.Prof.—Herrold, O'Conor
Instr.—Hirsch, Van Hazel

1929-30 Prof.—McKenna (ch)
Asst.Prof.—Herrold, O'Conor
Instr.—Hirsch, Platin, Van Hazel

1930-32 Prof.—McKenna (ch)
Asst.Prof.—Herrold, O'Conor
Instr.—Ewert, Hirsch, Platin

1932-33 Prof.—McKenna (ch)
Asst.Prof.—Herrold, O'Conor
Instr.—Ewert, Platin
Asst.—J.Gernon, McNally

1933-34 Prof.—McKenna (ch)
Assoc.Prof.—O'Conor
Asst.Prof.—Herrold
Assoc.—Hirsch
Instr.—Ewert, Platin
Asst.—J.Gernon, Schacht

1934-36 Prof.—McKenna (ch)
Assoc.Prof.—O'Conor
Asst.Prof.—Herrold
Assoc.—Ewert, Hirsch
Instr.—Platin, Ritch
Asst.—J.Gernon, Schacht

1936-37 Prof.—McKenna (ch)
Assoc.Prof.—Herrold, O'Conor
Assoc.—Ewert
Instr.—J.Gernon, Platin, Ritch
Asst.—Schacht

1937-38 Prof.—McKenna (ch)
Assoc. Prof.—Herrold, O'Conor
Instr.—J.Gernon, Platin, Ritch
Asst.—Cambridge, Drabanski, Dykhuizen, Kiefer, Riskind, Schacht, Sorenson,

1938-39 Prof.—McKenna (ch)
Asso.Prof.—Herrold, O'Conor
Assoc.—J.Gernon, Ritch
Instr.—Platin, Schacht
Asst.—Cambridge, Drabanski, Dykhuizen, Kiefer, Sorenson

1939-40 Prof.—McKenna (ch)
Assoc.Prof.—Herrold, O'Conor
Assoc.—J.Gernon, Kiefer, Ritch, Schacht
Instr.—Drabanski, Holm, Platin
Asst.—Sorenson

1940-41 Prof.—McKenna (ch)
Assoc.Prof.—Herrold, O'Conor
Assoc.—J.Gernon, Kiefer, Ritch, Schacht
Instr.—Drabanski, Holm, Platin
Asst.—Sokol, Sorenson

RUSH MEDICAL COLLEGE AFFILIATION

1942-43 Prof.—McKenna (ch), Herbst, Kretschmer
Assoc.Prof.—Herrold, O'Conor, Weller
Asst.Prof.—Buckman, Cottrell, Parker, Sullivan
Assoc.—Drabanski, J.Gernon, Heckel, Kiefer, Merricks, Ritch, Schacht
Instr.—Platin
Asst.—Gaines, German, Holm, Poremski, Ramberger, Sokol, Sorenson

1943-44 Prof.—McKenna (ch), Herbst, Kretschmer
Assoc.Prof.—Herrold, Weller
Asst.Prof.—Buckman, Cottrell, Heckel, Kiefer, Merricks, Parker, Sullivan
Assoc.—Drabanski, J.Gernon, Ritch, Schacht
Asst.—Bamberger, Gaines, German, Holm, Sokol, Sorenson

1945-46 Prof.—Herbst, Kretschmer
Assoc.Prof.—Kiefer (ch), Heckel, Herrold, Weller
Asst.Prof.—Buckman, Cottrell, Merricks, Parker, Sullivan
Assoc.—Drabanski, J.Gernon, Ritch, Schacht
Asst.—Bamberger, Gaines, Gernon, Holm, Poremski, Sokol

1948-49 Prof.—Herbst (Emer), Heckel, Kretschmer (Emer)
Assoc.Prof.—Kiefer (ch), Buckman, Herrold, Merricks, Vermuelen
Asst.Prof.—Cottrell, Ritch, Rudnick, Schacht
Assoc.—Drabanski
Instr.—Gaines
Asst.—McDonald

1949-50 Prof.—Herbst (Emer), Heckel, Kretschmer (Emer)
Assoc.Prof.—Kiefer (ch), Buckman, Herrold, Merricks, Vermuelen
Asst.Prof.—Cottrell, Ritch, Rudnick, Schacht
Assoc.—Drabanski
Instr.—Gaines
Asst.—Baumrucker, McDonald

1951-53 Prof.—Heckel
Assoc.Prof.—Kiefer (ch), Buckman, Herrold, Merricks, Vermuelen
Asst.Prof.—Baumrucker, Cottrell, Murray, Ritch, Rudnick, Schacht
Assoc.—Drabanski
Instr.—Cottrell, Gaines, McDonald
Asst.—Chan, Haddad

1953-55 Prof.—Heckel
Assoc.Prof.—Kiefer (ch), Buckman, Herrold, Merricks, Vermuelen
Asst.Prof.—Baumrucker, Cottrell, Murray, Ritch, Rudnick, Schacht
Assoc.—Drabanski
Instr.—Cottrell, Gaines, McDonald, Meyer, Papierniak
Asst.—Haddad, Wood

1956-58 Prof.—Heckel
Assoc.Prof.—Kiefer (ch), Buckman,

Herrold, Merricks

Asst.Prof.—Baumrucker, Cottrell (Emer.), McDonald, Murray, Papierniak, Ritch, Schacht

Assoc.—Drabanski

Instr.—Cottrell Jr., Gaines, Haeger, Meyer, Linke

Asst.—Gonzalez, McClellan

ST. LUKE'S HOSPITAL JOINS RUSH-PRESBYTERIAN HOSPITAL

1958-60

Prof.—Baker, Heckel

Assoc.Prof.—Kiefer (ch), Buckman, Grauer, Herrold (Emer.), Merricks

Asst.Prof.—Baumrucker, Drabanski, McDonald, Murray, Papierniak, Ritch, Schacht

Clin.Assoc.—Graf

Instr.—Callahan, Cottrell Jr., Firfer, Haeger, Mathis, Meyer, Valenta, Wiggishoff

Asst.—Calams, Deniz

1960-62

Prof.—Kiefer (ch), Heckel

Assoc.Prof.—Buckman (Emer.), Grauer, McDonald, Merricks

Asst.Prof.—Baumrucker, Drabanski, Graf, Meyer, Papierniak, Ritch, Schacht

Clin.Assoc.—Haeger

Instr.—Berry, Calams, Callahan, Cottrell Jr., Firfer, McKiel, Sozer, Valenta

Asst.—Flanagan, Gonzalez

1963-65

Prof.—Kiefer (ch), Heckel

Assoc.Prof.—Graf, Grauer, McDonald, Merricks

Asst.Prof.—Baumrucker, Blandy, Drabanski, Haeger, Meyer, Papierniak, Ritch, Schacht

Instr.—Berry, Calams, Callahan, Cottrell Jr., Deniz, Diaz, Flanagan, McKiel, Valenta, Wiggishoff

1966-68

Prof.—McDonald (ch), Kiefer

Assoc.Prof.—Graf, Merricks, Schacht (Emer.)

Asst.Prof.—Baumrucker, Berry, Cottrell Jr., Diaz, Drabanski, Flanagan, Haeger, McKiel, Meyer, Papierniak, Ritch (Emer.), Valenta, Wiggishoff

Instr.—Calams, Callahan, Cronin, Dahms, Deniz, Kozak, McClellan, Nadjani, Simpson, Watkins

Asst.—Choomsai, Flinn, Lowry, Zalar

1967-69

Prof.—McDonald (ch), Kiefer

Assoc.Prof.—Graf, Merricks, Schacht (Emer.)

Asst.Prof.—Baumrucker, Berry, Cottrell Jr., Diaz, Drabanski, Flanagan, Haeger, McKiel, Meyer, Papierniak, Ritch (Emer.) Valenta, Wiggishoff

Instr.—Calams, Callahan, Cronin, Dahms, Deniz, Kozak, McClellan, Nadjani, Simpson, Watkins

Asst.—Flinn, Lowry, Zalar

1969-71

Prof.—Kiefer (ch), King, McDonald

Assoc.Prof.—Baumrucker, Flanagan, Graf, McKiel, Merricks Schacht (Emer.), Wiggishoff

Asst.Prof.—Berry, Callahan, Clark, Cottrell Jr., Cruz, Dahms, Deniz, Diaz, Drabanski, Haeger, Kozak, Meyer, Papierniak, Ritch (Emer.), Simpson, Valenta

Instr.—Calams, Flinn, Morgan, Naci, Prudencio

Asst.—Misurec

RUSH-PRESBYTERIAN AFFILIATION ENDS

1972-74

Prof.—Kiefer (acting ch)

Assoc.Prof.—Baumrucker, Clark, Haeger, Schacht (Emer.), Wiggishoff

Asst.Prof.—Berry, Calams, Cruz, Dahms, Deniz, Diaz, Flinn, Kozak, Meyer, Ritch (Emer.), Simpson, Srinivasan

Instr.—Kumar, Misurec, Prudencio, Sutly

1975-76

Prof.—Kiefer (acting ch), Clark

Assoc.Prof.—Baumrucker (Emer.), Schacht (Emer.), Wiggishoff, Wilson

Asst.Prof.—Berry, Calams, Cruz, Cahms, Darwish, Deniz, Diaz, Flinn, Kozak, Meyer, Ritch (Emer.), Simpson, Srinivasan

Instr.—Behrens, Kumar, Malvar, Misurec, Prudencio, Sutly

1976-78

Prof.—Clark (acting ch), Kiefer

Assoc.Prof.—Baumrucker (Emer.), Schacht (Emer.), Wiggishoff, Wilson

Asst.Prof.—Berkson, Berry, Calams, Dahms, Darwish, Deniz, Diaz, Flinn, Guinan, Kozak, Meyer, Misurec, Ray, Ritch (Emer.), Simpson, Srinivasan

Instr.—Kumar, Malvar, Prudencio, Sharifi, Sutly

1978-80

Prof.—Clark, Kiefer (Emer.)

Assoc.Prof.—Baumrucker (Emer.), Schacht (Emer.), Wiggishoff, Wilson

Asst.Prof.—Guinan (ch), Berkson, Berry, Calams, Dahms, Darwish, Deniz, Diaz, Flinn, Kozak, Meyer, Misurec, Ray, Ritch (Emer.), Sharifi, Simpson, Srinivasan

Instr.—Kumar, Malvar, Prudencio, Sutly

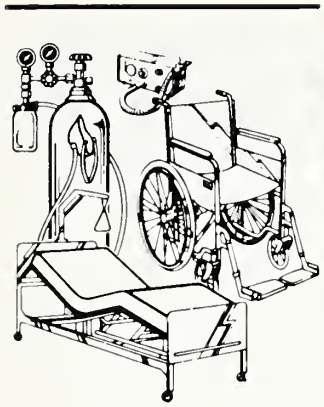
1980-82

Prof.—Clark, Kiefer (Emer.)

Assoc.Prof.—Guinan (ch), Baumrucker (Emer.), Darwish, Schacht (Emer.), Sharifi, Wiggishoff, Wilson

Asst.Prof.—Berkson, Berry, Calams, Dahms, Darwish, Deniz, Diaz, Flinn, Kozak, Meyer, Misurec, Ray, Ritch (Emer.), Simpson, Srinivasan

Instr.—Kumar, Malvar, Prudencio, Sutly



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Diplomate American Board of Radiology

Illinois Housestaff News

The Role of the Housestaff Association

At one time the small town and the "country Doc" were basic tenets of the social structure and medical care delivery. Much has changed in American medicine since World War II, with the growth of urban centers, technological advances and new emphasis on medical specialties.

Further evolution of our medical care delivery system is a certainty.

The impact of Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs), Health Maintainence Organizations (HMOs), and Emergicenters on the practice of medicine—and on the training of practitioners—will become evident by the turn of the century.[1]

Residency training programs have also undergone a reformation of sorts over the last 30 years. Better educational opportunities, technological advances, computers, higher salaries, and a recent concern for "stress in residencies" have improved the overall environment of the resident. These benefits are enjoyed not only by resident physicians, but presumably by their patients as well. Such positive gains are encouraging, yet new forces may act to stifle these trends.

Monetary considerations may pressure residency program directors either to reduce salaries or to offer fewer positions in their programs. In a time when the number of applicants for such positions has begun to outnumber the available training spots, the competition for these spots obviously increases. This is a sudden switch from past years when available positions were in great excess (and the "competition" was between training programs). This new "seller's market" gives little incentive to program directors for the continued improvement of the residents' environment. Worse, will the gains of the past generation be reversed in the next?

Current and future economic considerations demand that ongoing discussions continue between program directors and their residents. In some institutions housestaff associations which serve to protect the interests of their members have been organized. The National Labor Relations Board has denied residents the right to arbitration, which is based on a claim that residents are students. Yet, the IRS considers resident physicians employees and not students. It seems that only residents can speak for residents; a true need for better organization of residents within hospitals exists. A housestaff organization which defines problems and offers fair and equitable solutions may be the only medium through which residents can express their views.

Failure to understand the needs of the resident results in opposition to formation of housestaff associations. Such opposition is allegedly supported by platitudes similar to those which once were given to support objections to resident involvement and membership in county and state medical societies, the AMA, and specialty societies. Today, leaders and members of these societies speak of their resident members in superlatives and laud their initiatives and accomplishments. Housestaff associations within a hospital have a place; not only the residents will benefit.

Four years ago, the American Medical Association Resident Physicians Section produced an instructional kit which outlines the methods for establishing a housestaff association. Now, far more than in 1979, the need exists for such organizations.

To change is difficult, particularly in the medical profession. The Federal government, in response to concerns which have emerged from many quarters, has mandated new policies and change is going to occur. Practicing physicians as well as residents will have to make accommodations to deal adequately with this new legislation. Only as a group, both through organized medicine and housestaff associations, can residents' interests and rights be upheld. ◀

Michael L. Nieder, M.D.
Delegate, ISMS/RPS

References

1. Saward, E.W., Gallagher, E.K., "Reflections on Change in Medical Practice: The Current Trend to Large-Scale Medical Organizations," *JAMA* 250:20, November, 1983.

Medical News

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Stresses, such as surgery or acute illness, may increase the C-reactive protein in the serum or in synovial fluid. This increased C-reactive protein enhances the monosodium urate crystals to deplete complement and induce the inflammatory reaction. (Russell, I.J.: *J. Rheumatol* 10:425-33, 1983)

Dr. Kari Lehtinen evaluated 76 patients with ankylosing spondylitis and found that only 31 developed total or partial ossification of the spine and 14 showed Xray confirmation of erosion or ankylosis of a joint. Forty-one patients were continuing in their jobs. Only seven of the 76 patients with involvements in the hips and gleno-humeral joints as well as the spine had the worst outcome. Patients with spinal involvement only developed few complications. (*Scand. J. Rheumatol* 12:5-11, 1983)

Female patients over 60 with rapid onset of accentuated aging, vague neuromuscular symptoms, mental and physical fatigue as well as renal problems should be evaluated for possible hyperparathyroidism. In a prevalence study in 1,129 individuals over age 60, 2.5% had hypercalcemia and 1.5% showed typical symptoms and signs of hyperparathyroidism. Surgery revealed a single parathyroid adenoma in 80% of cases with amelioration of symptoms and feeling of well-being. (Tibblin, S., *et al.,: Ann Surg* 135-8, Feb. 1983.)

Pregnancy associated hypertensive patients were treated in two groups, one in the conventional manner and the other with atenolol, a beta-blocker. Both groups exhibited the same ratios of mental retardation, hypoglycemia, respiratory distress and hyperbilirubinemia in their infants. One third of the patients on the conventional treatment regimen showed no reduction in their blood pressures, and all of the patients on this beta-blocker responded with lowered blood pressures, reduced hospital admission rate and reduced respiratory distress. Proteinuria, once present, was not reversed by the beta-blocker, but did show a reduced occurrence in the early phase. (Rubin, P. C. *et al.,: Lancet* 1:431-4, Feb 1983.)

Another study evaluated the use of diuretics in pregnant women with hypertension and a control group of normotensives. The mean plasma volume was significantly reduced with the diuretics initially, but subsequent determinations showed no differences in plasma volumes between the control and treated groups. After diuretics were discontinued, the hypertensive group showed a rebound phenomenon. The plasma volume increased by 28% but the control group by only 7%. The 8% perinatal incidence of mental retardation was equal for the hypertensive and normotensive groups. (Sibai, B.M. *et al.,: Am J Obstet Gynecol* 145:539-44, March 1983.)

Dr. Rahimtoola, *et al.,* surveyed 1282 patients who had undergone coronary artery bypass grafting between 1970 and 1982. The operative mortality rate prior to 1973 was 2.5% and then dropped to 1.7%. The survival rate at five years was 92+/−1%. At 10 years it was 83+/−2%. Within the first five year period, 1.2% of patients required resurgery. Between the sixth and tenth years, 2.2% required resurgery. Five percent of all patients remained with disabling angina. Fourteen percent presented with angina on ordinary exertion, 20% were minimally symptomatic and 61% remained asymptomatic. These results appear to compare favorably with medical managements. (Rahimtoola, S.H. *et al., N. Engl J Med* 308:676-81, 1983)

A similar study for a five year period was undertaken by Dr. Frick, *et al.,* on 100 men younger than 65 years in age. Their results confirm the general clinical improvements and the benefit of coronary artery bypass grafting on the exercise tolerance. They further seem to indicate however that the adjunctive use of beta-blockers may enhance the beneficial effects of the surgery. (Frick, M.H. *et al.,: Circulation* 67:491-6, Mar 1983)

A double blind, randomized, placebo controlled study evaluated chronic oral isosorbide dinitrate therapy in patients with moderate to severe congestive heart failure. A tolerance to the systemic arteriolar effect developed without loss in benefit to the systemic and pulmonary vascular systems. This

medication reduced the pulmonary capillary wedge pressure, the mean systemic and pulmonary arterial pressures and the systemic and pulmonary vascular resistance. Patients so medicated improved significantly in clinical status and exercise tolerance. (Leier, C.V. *et al.,: Circulation* 67:817-22, Apr 1983)

In another feature, authors reviewed efficacy of the various cardiac screening techniques for patients older than 35 and asymptomatic for coronary artery disease. Exercise testing yielded a sensitivity of 30-67% with an unacceptably high percentage of false positive results and a low percentage of true pathology. Cardiokymography was more specific, 74% accurate, and thallium-201 scanning was most specific with accuracy of 90%. The presence of a risk factor and two abnormal stress test variables indicated two or three vessel disease angiographically in 84% of cases. The suggested approach in asymptomatic patients included a good history to include anginal and risk factor data, high density lipoprotein cholesterol and a resting EKG. This may be followed by a maximal stress exercise test and lastly a thallium scintigraph, cardiokymograph, or cardiac fluoroscopy. (Uhl, G.S., Froelicher, V.: *J Am Coll Cardiol* 1:946-55 Mar., 1983)

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EKG

(Continued from page 463)

Answers: 1. C 2. A, B

Each ECG strip starts with one or two sinus beats. The ST segment of the sinus beat preceding the tachycardia is distorted. The distortion in the ST segment is caused by an ectopic P wave. The cycles of the tachycardia are slightly irregular but they are comparable from episode to episode at a rate of 150 beats per minute. The second and third beats in the top strip are likely to be atrial premature beats with aberrant intraventricular conduction. The shape of the QRS in these two beats resembles the QRS morphology in the burst of tachycardia seen in the bottom strip. This is paroxysmal supraventricular tachycardia occasionally demonstrating aberrant intraventricular conduction. The sinus beats show significant Q waves compatible with the old myocardial infarction. Although the patient had a slow sinus rhythm at rates around 60 beats per minute, he had no symptomatic asystolic periods and denied any syncope or near syncope.

An electrophysiologic study is optional in this case. Our patient had this examination. The supraventricular tachycardia was easily induced by timed atrial extrastimuli and was similarly interrupted. However, it was not the more common AV nodal reentry tachycardia but, instead, an intra-atrial reentry tachycardia with a high to low sequence of atrial activation suggesting a sinus node reentry tachycardia. There was no evidence of sinus node dysfunction but there was an atrial pacing induced lengthening of the His-Purkinje (H-V) interval. This suggested early disease in the His-Purkinje or intraventricular conduction system. No dropped beats were induced. Digoxin successfully eliminated the paroxysmal supraventricular tachycardia.

Doctor's News

PHYSICIANS IN THE NEWS—John W. Curtin, M.D., Winnetka, chairman of the department of plastic and reconstructive surgery at Rush-Presbyterian-St. Luke's Medical Center, was re-elected chairman of the advisory council for plastic and maxillofacial surgery of the American College of Surgeons. In addition, Dr. Curtin was elected overall chairman for the advisory councils of all other (eleven) surgical specialties.

Emilo Barrera, M.D., Park Ridge, was one of seven physicians to receive the Passionist golden heart award this Fall at the twentieth annual passionist monastery dinner dance.

Joseph P. McKay, M.D., Oak Brook, and **Joseph A. Wells, M.D.,** Snowmass, Colorado, Loyola University alumni, received the Stritch Medals at the Loyola University annual award dinner in November.

The following physicians have been elected to fellowship in the American College of Physicians: **Sohrab Mobarhan, M.D.,** Chicago; **Neal Ruggie, M.D.,** Glencoe; **E. Osanloo, M.D.,** Naperville; **Jimmy L. Roberts, M.D.,** Oak Park; **Stuart Rich, M.D.,** Skokie; **Seymour N. Herschberg, M.D.,** Winnetka; and **Terry Meriden, M.D.,** Pekin.

Melvin Post, M.D., Chicago, chairman, department of orthopedic surgery, Michael Reese Hospital and Medical Center, has been honored with the the Chicago Medical School's distinguished alumni award.

David D. Caldarelli, M.D., Evanston, has been named the Stanton A. Friedberg, M.D. Professor of Otolaryngology and Bronchoesophagology at Rush-Presbyterian-St. Luke's Medical Center.

PATIENT MEDICATION INSTRUCTION SHEETS—Sixty patient medication instruction (PMI) sheets are now available from the AMA. PMIs describe the uses and side effects of drugs in easily understood language. The most recent addition to available PMI sheets are those for OTCs: antihistamines used for motion sickness, allergies and insomnia; bronchodilator aerosols; aspirin and acetaminophen. The PMI program is sponsored by the AMA Education and Research Foundation. The minimum order for PMIs is 10 pads (100 sheets per pad) for $5 prepaid to AMA Order Dept., PO Box 8052, Rolling Meadows, IL 60008.

NATIONAL GUARD SCHOLARSHIPS—Eight University of Illinois medical students recently received two-year Illinois Army National Guard Scholarships. The 100% tuition paid scholarships are part of a program designed to involve medical students in the three National Guard medical units in Illinois.

CALCIUM BLOCKER USED FOR MIGRAINES—Verapamil, a calcium channel blocking agent originally intended for treating heart problems, can reduce the frequency of migraine headaches and relieve migraine pain, according to a recent AMA news release.

According to Wright State University and Wright-Patterson Air Force Base researchers, "verapamil is highly effective in the prophylactic treatment of both classic (severe) and common (less severe) migraines." The calcium channel blocker not only lessens the severity of migraine attacks but also prevents the attacks from occurring according to the Ohio researchers. Reports of these findings and an AMA Council on Scientific Affairs report on the efficacy of calcium channel blockers appear in the November 11 issue of *JAMA*.

NEW ALZHEIMER'S DISEASE ASSOCIATION CHAPTERS—The Alzheimer's Disease and Related Disorders Association (ADRDA) is certifying 13 new chapters in 10 states, including Illinois, according to a recent ADRDA news release. The Chicago-based national volunteer health organization, formed in 1980, has 79 chapters with these additions as well as 350 support groups in the United States. For information about Alzheimer's Disease and ADRDA call the Illinois toll free number at 1-800-572-6037.

AIDS RESEARCH FUNDS—The Howard Brown Memorial Clinic, Chicago, will receive $2.97 million during the next four years from the National Institutes of Health to study the history of Acquired Immune Deficiency Syndrome (AIDS) among homosexually active men, according to a recent HBMC news release. Northwestern University Medical School is collaborating in the project and will receive approximately $1.74 million of the total amount to conduct immunologic testing and provide statistical and data management support.

TAPES ON AIDS—The Chicago Medical Society has a Tel-Med tape available on Acquired Immune Deficiency Syndrome (AIDS). Tel-Med is a free public service that provides information on a variety of illnesses and injuries. The Tel-Med telephone number is (312) 670-3670. The AIDS tape number is 571.

MEDICAL SCHOOL ENROLLMENTS—Enrollment of first year medical students has decreased for the first time in 17 years, according to a recent AMA news release. Possible reasons given included cutbacks of medical school subsidies by states and schools changing from three-year to four-year programs.



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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BREESE: Serving population 25,000. 40 miles east of St. Louis, near Carlyle Lake. Need OB-Gyn physicians to share practice with present OB-Gyn physician. Need family practice. Quality schools and colleges in area. Financial assistance available. CONTACT: Sr. Mary Anthony, St. Joseph's Hospital, Breese, 62230, (618) 526-4511. (11)

LA HARPE: Population 1200. Seeking replacement for one or two family physicians in community. 64 bed hospital including 49 long term; affiliation with nearby regional medical center; office facilities and financial assistance available. Educational/recreational facilities. Mississippi River nearby. Contact: Richard Miller, Administrator, La Harpe Hospital, La Harpe 61450, 217/659-3011. (1)

LEMONT: OB-GYN—Board certified or board eligible. Growing community—thirty minutes southwest of Chicago. Congenial physician group. Many fringe benefits—salary negotiable. Excellent practice opportunities. Contact Barry Ladd, M.D., 217 E. 127th. Street, Lemont, 60439. 312-257-2265. (1)

LINCOLN: Openings for two family practitioners and one OB/GYN in central Illinois. Local hospital is a progressive 133 bed community hospital with a population base of 40,000, in a two county area. Lincoln is a hub for five major cities that have major universities, tertiary care centers, shopping, recreational and cultural activities. Contact D. David Sniff, Administrator, Abraham Lincoln Memorial Hospital, Lincoln 62656, 217-732-2161.

MONMOUTH: Family practice physician needed immediately to assume well established practice in thriving Illinois agricultural community. 15 minutes from 91-bed JCAH accredited hospital with range of support services. Major university, private college and recreational facilities nearby. Submit C.V. to Victoria Hennenfent, Community Memorial Hospital, Monmouth, 61462 (309) 734-3141. (11)

PARIS: Service area 30,000. Practice independently or join an established group. Openings for family practitioners, internists, general surgeons, pediatricians and OB/GYN. Modern 100 bed hospital. Liberal financial package available. Thirty miles from Terre Haute, Indiana. Varied recreational activities nearby. Contact: Thomas E. Cecconi, Administrator, Paris Community Hospital, East Court Street, Paris, 217/465-4141. (1)

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AAMA Annual Meeting

By Betty Kronemeyer, CMA, President

The opening session of the 1983 House of Delegates of the AAMA was called to order by speaker of the house, Luella Mitchell, CMA, at the Sheraton Centre, New York, Tuesday, October 11, 1983.

Delegates of two newly affiliated states were seated. The Idaho flag was presented by Physician Advisor Kenneth Orter, M.D., and the North Dakota flag was presented by Physician Advisor J. Gordon Felt, M.D.

There were 595 registered, including international guests from the Canadian Provinces of Ontario and Manitoba. Reference committees were appointed, reports were read and accepted and the proposed bylaws adopted with two amendments.

The official slate of nominees for officers and trustees was presented with no nominations from the floor. Each gave her candid talk. Those elected were: president-Janet Hensinger, CMA-A, Kentucky; president-elect-Ivy Reade, CMA-AC, New York; vice-president-Rita Paris, RT, LVN, CMA-AC, Texas and secretary-treasurer-Ann M. Jordana, RT, CMA-AC, Florida (re-elected). Trustees elected were (two-year term): Janet Binkowski, RN, Illinois; Juanita N. Blocker, LPN, CMA-C, Alabama; Bonnie Landers, CMA, Georgia; MiMi Quinn, CMA-A, Kentucky and Juanita M. Selk, CMA-C, Oregon. Nominating committee members named were: June Hirsch, CMA-AC, Wisconsin; Roseanne DeGennaro, CMA, New Jersey; Kathleen Skiby, CMA, Colorado and Shirley Trammell, CMA-A, Georgia. Robert Hartman, M.D., Illinois, was elected physician advisor. Executive director Ina Yenerich, RT, CMA-AC, called for volunteers from the states to participate in the two new pilot programs outlined in the four year strategic plan and invited members to visit the Chicago AAMA office.

Laura L. Lockhart, CMA-AC, retiring chairman of the curriculum review board, explained the essentials revision process and gave a timetable for its completion. She announced that AAMA's petition for continued recognition as an accrediting agency has been accepted by the Council of Postsecondary Accreditation and that the results would soon be forthcoming. Her report also commended medical assisting program surveyors and announced that a survey or training workshop is under consideration.

Jean Keenon, CMA-A, certifying board chairman, reported that the financial situation was improving, discussed the need to encourage more members to take the examination and stressed the need for revalidation.

Continuing education board chairman Rachel Younger, CMA-AC, announced that the law of medical office guided study course is in the final stages for production, that four more package programs have been added to those available to states and chapters and that eleven states will be implementing the professional achievement award. She also announced "New Populations" as the theme for the 1984 Portland convention, and "Focus on the Future" as the theme for the 1985 Lexington convention.

Awards received by Illinois were: first in the percentage increase and second in the numerical increase in membership (Rock Island chapter). Macon County chapter, Decatur, received an award for 100% membership stabilization.

Highlights of AAMA Strategic Plan: Pilot studies are being done on advantages of nationally sponsored regional conferences. The annual meeting will be restructured by 1986 to include an

annual business meeting held near Chicago, and five regional "mini-conventions." On-site membership recruitment through nationally sponsored continuing education workshops would be held.

The plan is comprised of strategies, or activities, that the national leadership (volunteers and staff) will implement to achieve specific objectives. The objectives have been grouped by key areas in which AAMA must obtain results. The key result areas listed in order of funding priority are: association management, membership recruitment, public relations (external), member relations and retention, certification, continuing education, protect the medical assistant's right to practice, accreditation and leadership development.

The national dues for student members will be only $10.00. New members paying full dues will receive a national AAMA pin and decal when they join. Those paying full dues for 1984 renewal membership before March first will receive a one-year accidental death and dismemberment insurance policy as an additional benefit of national level membership. The plan provides that by 1986 renewal notices will be mailed directly to current members and paid directly through the national organization. Credit card payment may be offered as an option.

We were honored to have Frank J. Jirka, Jr., M.D., AMA president, as speaker at the national AAMA installation ceremony. ◀

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JANUARY

Internal Medicine

The Year in Internal Medicine
For: MD's. Workshop, Jan, 25-28, Chicago. **Spansar:** The Alumni Center for Continuing Educotion, Northwestern University Medicol School, 301 E. Chicago Ave., Chicago 60611. **Fee:** $205.00 + $18.00 additionol for each workshop ottended. **Credit:** AMA Category 1, 22 hours. **Contact:** The Alumni Center for Continuing Educotion. **Phone:** 312/649-8533.

Psychiatry

Lake Caunty Medical/Surgical/Psychiatry Seminar
For: MD's. Seminor, Jon. 25, 8:00 om—Noon, Mother Leonordo Conference Center, St. Thereso Hospitol, Woukegon. **Spansar:** St. Thereso Hospitol, 2615 Woshington, Woukegon 60085. **Fee:** $10.00. **Reg. Limit:** none. **Credit:** Category 1, 4 hours. **Cantact:** Dr. R. M. Adelmon. **Phane:** 312/578-2555.

Sports Medicine

Howkeye Sports Medicine Symposium
For: MD's, RN's, EMT's, PT's, cooches & trainers. Symposium, Jon. 5-7, 8:00—5:00 pm, Iowo City, Iowo. **Sponsor:** University of Iowo College of Medicine, Continuing Medicol Education, UI College of Medicine, 285 Med Lobs, Iowo City 52242. **Fee:** $225.00-MD's, $110.00-all others. **Reg. Limit:** none. **Credit:** Category 1, 17.5 hours; AAFP Prescribed, 17.5 hours. **Phane:** 319/353-5763.

Family Medicine

Medical Seminar-At-Sea
For: MD's. Seminor, Jon. 8-19. Coribbeon Seo. **Spansar:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Reg Deadline:** none. **Fee:** Yes. **Reg. Limit:** none. **Credit:** Category 1, 48 hours. **Cantact:** Lorroine Stephenson. **Phane:** 217/782-7711.

Surgery

Specialty Review in Generol Surgery, Part II
For: Surgeons. Lecture, Jon. 23-Feb. 2, Chicogo. **Sponsor:** Cook County Groduote School of Medicine, 707 South Wood St., Chicogo 60612. **Fee:** $675.00. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Boker, M.D. **Phone:** 312/733-2800.

FEBRUARY

Diabetes

Current Concepts in Diabetes Mellitus
For: MD's, RN's & dieticions. Lecture, Feb. 10-11, Urbono. **Sponsar:** Corle Foundotion Hospitol, Deportment of Medicol Educotion, 611 West Pork St., Urbono 61801. **Fee:** $100.00, Sot. only $35.00 **Reg. Deadline:** Feb. 3. **Credit:** AAFP Elective, 10.5 hours, AMA Category 1, 10.5 hours. **Contact:** Deborah C. Rugg. **Phone:** 217/337-3022.

Medicine

Medicine Grand Raunds
For: MD's. Lecture, Wednesdoys, 11:30-12:15pm, North Chicogo. **Spansor:** University of Heolth Sciences/The Chicogo Medicol School, 3333 Green Boy Rd., North Chicogo 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 1 hour. **Contact:** Dr. Ben B. Blivoiss, 312/578-3215.

Practice Management

Chaasing and Using a Camputer in a Privote Medical Practice
For: Lecture, Feb. 10-11, 8:00-5:00pm, Los Vegas. **Spansar:** University of Heolth Sciences/The Chicogo Medicol School, 3333 Green Boy Rd., North Chicogo 60064. **Fee:** $295.00. **Credit:** AMA Category 1, 16 hours. **Contact:** Dr. Ben B. Blivoiss. **Phane:** 312/578-3215.

Practice Management

Chaasing & Using a Computer in a Private Medical Practice
Lecture, Feb. 24-25, 8am-5pm, Atlonta, Georgio. **Spansar:** University of Heolth Sciences/The Chicogo Medicol School, 3333 Green Boy Rd., North Chicogo 60064. **Fee:** $295.00. **Reg. Limit:** none. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivoiss, MD **Phane:** 312/578-3215.

Gastroenterology

Gastraenteralagy Sympasium
For: MD's. Symposium, Feb. 3, Springfield. **Spansar:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** Yes. **Reg. Limit:** None. **Credit:** Category 1, TBA. AAFP Prescribed, TBA. **Cantact:** Lorroine Stephenson. **Phane:** 217/782-7711.

Medical Education

Evaluation af Clinical Campetence
Workshop, Feb. 9-10, Springfield. **Sponsar:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** Yes. **Reg. Limit:** TBA. **Credit:** Category 1, TBA. **Contact:** Lorroine Stephenson. **Phane:** 217/782-7711.

Family Medicine

Medical Seminar-At-Sea
For: MD's. Seminor, Feb. 18-Morch 5, Ponomo Conol. **Spansor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** Yes. **Reg. Limit:** None. **Credit:** Category 1, 66 hours. **Cantact:** Lorroine Stephenson. **Phane:** 217/782-7711.

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Neurology

Basic Science of Neurology
For: Neurologists, Psychiatrists. Lecture, Feb. 20-24, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood. St., Chicago 60612. **Fee:** $450.00 **Reg. Limit:** 90. **Credit:** Category 1, 42 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Surgery

Review Course of Neurological Surgery
For: Neurosurgeons, Neurologists. Lecture, Feb. 3-12, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675.00. **Reg. Limit:** None. **Credit:** Category 1, 101 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Surgery

Specialty Review in Pediatric Surgery
For: Surgeons. Lecture, Feb. 6-9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390.00. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Family Practice

Advances in Family Practice
For: MD's. Lecture, Feb. 13-17, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390.00. **Reg. Limit:** 150. **Credit:** Category 1, 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

MARCH

Licensure

State & National Board Review, Clinical
For: MD's taking State Licensure Exams. Lecture, Mar. 26-31, Chicago **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510.00. **Reg. Limit:** 90. **Credit:** Category 1, 56 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Licensure

State & National Board Review, Basic
For: MD's taking state licensure exams. Lecture, Mar. 19-25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510.00. **Reg. Limit:** 90. **Credit:** Category 1, 62 hours. **Contact:** Robert J. Baker, MD **Phone:** 312/733-2800.

Dermatology

Pediatric Dermatology
For: MD's. Lecture, Mar. 19-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $280.00. **Reg. Limit:** 55. **Credit:** Category 1, 21 hours. **Contact:** Robert J. Baker, MD **Phone:** 312/733-2800.

Psychiatry

Specialty Review in Psychiatry
For: Psychiatrists; and Neurologists. Lecture, Mar. 12-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480.00. **Reg. Limit:** 55. **Credit:** Category 1, 45 hours. **Contact:** Robert J. Baker, MD **Phone:** 312/733-2800.

Medicine

Seizure Symposium
For: MD's. Symposium, March 16, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA. AAFP Prescribed, TBA. **Contact:** Lorraine Stephenson **Phone:** 217/782-7711.

Practice Management

Choosing & Using a Computer in a Private Medical Practice
Lecture, Mar. 9-10, 8am-5pm, San Antonio, Texas. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivoiss, M.D. **Phone:** 312/578-3215.

Medicine

Choosing & Using a Computer in a Private Medical Practice
Lecture, March 23-24, 8am-5pm, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Dr. Ben B Blivaiss. **Phone:** 312/578-3215.

Surgery

Surgery Visiting Professor Lecture Series
For: MD's Lecture, Mar. 14, 8am-5pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivoiss, M.D. **Phone:** 312/578-3215.

Ophthalmology

8th Annual Ophthamology Current Concepts Seminar '84
For: Ophthomologists & RN's. Conference with workshops, March 22-24, Madison, Wisconsin. **Sponsor:** University of Wisconsin, School of Medicine, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** none. **Credit:** Category 1, TBA. **Other:** UW-Extension, Continuing Education Units, TBA. **Contact:** Sorah Aslakson. **Phone:** 608/263-2856.

Pulmonary Diseases

3rd Annual Symposium on Chronic Obstructive Pulmonary Diseases
For: MD's, physicol therapists. Symposium, Workshops, Mar. 8-9, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medicol Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** none. **Credit:** Category 1, TBA, Other: UW-Extension, Continuing Education Units, TBA. **Contact:** Sarah Aslokson. **Phone:** 608/263-2856

Coronary Artery Disease

Recent Advancement in Treatment of Coronary Artery Disease
For: MD's. Symposium, March 8, 1pm-5pm, DuQuoin, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, 62708. **Fee:** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours, AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson **Phone:** 217/782-7711.

Family Medicine

Medical Seminar-At-Sea
For: MD's. Seminar, March 15-25, Coribbean Sea. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

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